

33 YEARS OF ARMY NURSING



**An Interview
with
Brigadier General
Lillian Dunlap**

*Conducted by
Cynthia A. Gurney*

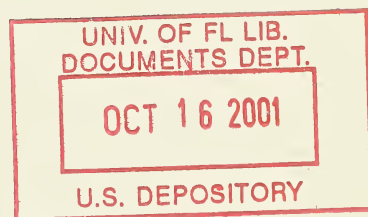




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Cynthia A. Gurney
Colonel, USA (Ret.)*



*United States Army Nurse Corps
Washington, D.C., 2001*

Foreword

Although twenty-five years have elapsed since her retirement, Lillian Dunlap's mark on the United States Army and the Army Medical Department endures. Survey the life and accomplishments of this soldier-nurse and lay to rest forever any doubts on the potential impact of one individual on an organization and its culture. In this volume, General Dunlap recounts in painstaking detail her early years, her distinguished career as an Army officer, and the challenging years of her tenure as Chief of the Army Nurse Corps. She paints a picture for us of the arduous work of nurses in the Pacific theater during World War II. Problem-solve with her the issues of the postwar drawdown followed, tragically, by the unexpected buildup for Korea. Her story is one of continuous, steady progress through clinical, staff, and educational positions as she builds her leadership repertoire. Lillian Dunlap's experiences define for us the evolving roles and challenges for nurses in the Army as well as for women in the military. Through those developmental years, her viewpoint is that of the individual. As her scope of responsibility expands, so too does her perspective as she reveals the background and decision-making processes that accompany the evolution of the profession of nursing and the Army Nurse Corps. First and foremost, General Dunlap presents to us a framework for leadership that rests on collaboration, cooperation, and empowerment.

Historians, military nurses past and present, and potential leaders will find invaluable this firsthand account of issues related to women in the military, men in nursing, the profession of nursing, and the dynamics of periodic power struggles between the Army Medical Department and the U.S. Army. This volume offers a primary account of ever-evolving Army Medical Department infrastructure and the many changes associated with the professional development of its officer and non-commissioned officer corps. It explicates the complexities of collaborative relationships among military departments and between civilian and military agencies.

The Army Surgeon General's Office and the Army Nurse Corps are grateful to the Center of Military History, under the leadership of Brig. Gen. John S. Brown, for making this volume possible. Through the work of Army Nurse Corps historians past and present, this rich account of lessons learned has been captured, synthesized, and disseminated. Brig. Gen. Lillian Dunlap has generously shared with us the good times and the bad. Let us now put it to work to shape a future that allows us to perform our mission of "Conserving the Fighting Strength."

Washington, D.C.
2 February 2001

WILLIAM T. BESTER
Brigadier General, AN
Chief, Army Nurse Corps, and Assistant
Surgeon General for Force Projection

The Interviewer

Col. Cynthia A. Gurney

Cynthia Gurney entered the Army Nurse Corps through the Army Student Nurse Program during the later stages of the war in Vietnam. She began her military career as a critical care nurse and later served as Head Nurse of Medical Intensive Care at Walter Reed Army Medical Center. She obtained a master's degree in nursing and continued her specialty in critical care as a clinical nurse specialist and later as Deputy Director of the Army Nurse Corps' critical care nursing course at Brooke Army Medical Center. After attending the Army's Command and General Staff College in residence, she served as the Army Nurse Corps Historian, making historical presentations to audiences around the country and publishing articles on military nursing history. In 1990, after obtaining a Ph.D. in nursing and an MBA from the University of Illinois at Chicago, she began an assignment in nursing research at Walter Reed Army Medical Center, rising to Chief of the Nursing Research Service. During this period, Colonel Gurney cofounded the Tri-Service Nursing Research Program, which currently manages programmatic funding for selected military nursing research projects. Her six-year tour at Walter Reed was interrupted for six months in 1992 while Colonel Gurney served as Chief Nurse of the Medical Element, Joint Task Force-Bravo, Honduras. She twice more served as Chief Nurse of deployable hospitals: the 85th General Hospital, Fort Meade, Maryland, and the 41st Combat Support Hospital, Fort Sam Houston, Texas. Colonel Gurney ended her 28-year military career as Chief of the Nursing Education and Research Service at Brooke Army Medical Center. She currently serves as Director, Research and Planning, for the New York State Nurses Association.

Brig. Gen. Lillian Dunlap

Lillian Dunlap, fourteenth Chief of the Army Nurse Corps, entered the Army Nurse Corps in San Antonio, Texas, in November 1942. After serving in the Pacific theater during World War II, she returned to clinical nursing positions at Brooke General Hospital, Texas, and Camp Chaffee, Arkansas. Demonstrating early potential for leadership, she became Chief Nurse at Camp Chaffee, Arkansas; served briefly at Fort Hood, Texas; and moved to a staff position at Fourth Army headquarters. After completing her undergraduate degree, she assumed a clinical leadership role at the 98th General Hospital in Europe and later at Fort Jackson, South Carolina. She attended the Army-Baylor Hospital Administration Course, and following her residency at Fitzsimons Army Medical Center she was awarded a master's degree in hospital administration. She returned to the Medical Field Service School (MFSS), where she taught for five years, and rose to the position of Director of the Department of Nursing. As a senior leader, Lillian Dunlap served as Chief Nurse of the Army hospital on Okinawa, Chief of the Army Nurse Corps Assignment Branch, and Chief Nurse of First Army, where she was instrumental in defining and implementing the MEDDAC (Medical Department Activity) concept. After a brief period as Chief Nurse at Walter Reed Army Medical Center, she was selected for the position of Chief, Army Nurse Corps, and for promotion to brigadier general. As American involvement in the Vietnam War drew to a close, General Dunlap oversaw extraordinary advances in Army nursing including the implementation of the Army Nurse Clinician Program and the establishment of multiple Army postgraduate programs for advanced practice nursing. She assured the success of the baccalaureate degree as the standard for entry into practice for Army Nurses. General Dunlap now resides in San Antonio, Texas, where she remains active in community and professional activities. She is president of the Army Medical Department Museum Foundation and a fellow of the American Academy of Nursing.



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Preface

When we embarked on interviews for this oral history, little did we know that it would be fifteen years before we could wrap it up. We conducted over twenty-five hours of interviews between November 1986 and August 1987. The contemporary Surgeon General, Lt. Gen. Quinn Becker; Chief of Military History, Brig. Gen. William Stofft; and Chief, Army Nurse Corps, Brig. Gen. Connie L. Slewitzke, supported transcription of the tapes. After each transcript was completely validated against the audiotapes, Colonel Gurney edited the text. General Dunlap then reviewed it to verify dates and times of events and names of persons and places with an encyclopedic memory that easily outpaces that of professional historians. Colonel Gurney continued the editing, overall organization of the text, and graphics layout. Ongoing advances in technology enabled this oral history to reach beyond the traditional bounds of the Army Nurse Corps Oral History Program, with the addition of photographs and an index to make key historical content accessible to future historians.

This has been a labor of love made possible by supportive families and coworkers. Of special note are the many organizations that supported this project by providing time and resources to Colonel Gurney. They included Walter Reed and Brooke Army Medical Centers and the U.S. Army Center of Military History. General Dunlap is indebted to Colonel Gurney for making this publication possible. She overcame numerous obstacles including changes in duty assignment and the occasional inaccessibility of General Dunlap. Colonel Gurney's endless hours, consummate professional talents, creative use of advanced technology, and commitment to excellence are applauded. Of special note was the expert counsel provided by Glenn Gueller, Martha Reyna and Suzie Castellaw of Visual Informatics at Brooke. Catherine Heerin and Beth MacKenzie at the Center of Military saw the book through to publication.

We are joined in the fervent hope that this very personal, yet landmark account of a full generation of Army Nurse Corps history will be widely available to scholars and enthusiasts worldwide. This account offers a unique perspective on women's history, military nursing history, and clinical practice as it evolved between 1942 and 1975. There is no more fascinating or charming way to explore our legacy. It is a road we have been proud to travel.

CYNTHIA A. GURNEY
Colonel, USA (Ret.)

LILLIAN DUNAP
Brigadier General, USA (Ret.)

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 American troops leave post chapel, Admiralty Islands
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Colonel Dunlap with senior advisory staff, Okinawa, 1965
With church personnel, Easter 1966
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Senior Army Nurse Corps leaders, 1966
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Brig. Gen. Anna Mae Hays, Colonel Dunlap, and Mr. Ira Dunlap at General
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Reviewing honor guard, Fort Benning, 1972
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Stanley
General Dunlap's official portrait
Breaking ground for the Army Medical Department Museum, Fort Sam
Houston, 1988
Aboard the *General Lil*, Riverwalk, San Antonio

Cover: Brig. Gen. Lillian Dunlap, Chief, Army Nurse Corps, 1971–1975
[Brooks Photographers]

33 Years of Army Nursing

The Formative Years

Life Before the Army

CHILDHOOD

MAJ Gurney: General Dunlap, it is quite a pleasure to visit with you today to record and share your thoughts and experiences. I hope we don't exhaust you. As we begin to talk about your early career, it would be really interesting to know some of the early life experiences which may have contributed to your decision to become a nurse and a distinguished career officer in the Army Nurse Corps. Can you tell me a little bit about your family and your childhood experiences?

BG Dunlap: I am the oldest of five girls born to Mary and Ira Dunlap, and the only nurse in the family. None of my relatives were nurses, so it was not family traditions that led to my career choice. I think there is possibly just something in a person that determines what career they follow. As an example, Mother tells the story of an incident that happened when I was very young. I hadn't even yet started school. One day mothers of several of my playmates called and asked my mother if I was feeling all right. She said "Yes, why?" Well, their little children had diarrhea. It seems I had gotten the pink calomel pills out of Mother's medicine cabinet and played like I was a doctor taking care of my little playmates. There must have been something in me, at that point even, that would determine that I would go into nursing.

There were other possible influences. Naturally, being the oldest of five girls, I had to take care of my baby sisters. We didn't have babysitters in those days. I think that possibly might have had some impact on me also. In high school I was interested in science, and I concentrated on sciences in school. I also had some friends who were nurses.

Even so, I had an uncle who felt that nursing was not an appropriate career for a young woman. My parents were middle income. We didn't consider ourselves poor, but we knew people who had less than we did and some who had more. But we had a lot of love and lots of happiness. I wanted to go into nursing, but Mother didn't have the \$150 that it took to enroll in nursing school. This uncle could have paid for it, but he wouldn't because he didn't want me to be a nurse. He wanted me to be a commercial artist, since I had demonstrated some talents in that area. If I had decided to become a commercial artist, he would have paid for my schooling. Since I wanted to be a nurse, he wouldn't pay for it. My dear mother saved money, and I worked a little doing some babysitting and also some artwork. Then an uncle in Corpus [Christi, Texas] let Mother borrow some

money so that we had \$150 for me to go into nurses' training at Santa Rosa Hospital School of Nursing.

MAJ Gurney: You told me a little earlier that you had an accelerated course through school.

BG Dunlap: Yes, I started school when I was six years old and made the first two grades in the first year. So I went on into the third grade at the end of my first year in school. As a result, I graduated from high school at age 16.

MAJ Gurney: It must have been difficult to try to begin to meet your career goals when you were only 16. Did you have some trouble getting into school?

NURSING SCHOOL

BG Dunlap: They wouldn't accept me because I was 16 years old and they required students be 18 to enter a school of nursing. I stayed out that one year and went to the University of San Antonio. It was out near Woodlawn Lake then, but it doesn't exist now. I continued to do some artwork: making invitations, table decorations, and things like that to help raise money for me to go into nursing. When I was 17 years old, I went down to see Sister Mary Andrew at Santa Rosa Hospital School of Nursing here at San Antonio. She said, "Well, you're only 17 but you're more mature at 17 than some of our students are at 18, so we'll go ahead and accept you into nursing." So, I went into nursing at age 17.

MAJ Gurney: That's fantastic. Tell me about nursing school. What was nursing school like in 1939? Things were beginning to happen in the world about that time.

BG Dunlap: Actually, we weren't aware of things happening in the world. We didn't have TV at that time. We certainly weren't aware of what was going on outside San Antonio, or even in San Antonio. Certainly not as much as people are today.

I went into Santa Rosa Hospital School of Nursing, which of course was a three-year school of nursing. It was affiliated with Incarnate Word College. Every Monday of our first year, we would go on duty on the floors in the morning, get off at noon, dash over for lunch, board the bus, and go to Incarnate Word College for a full afternoon of chemistry. We had 6 hours of chemistry. Then we came back and grabbed a cold supper, returned to duty on the floors to give PM care. We gave PM care in those days. We were responsible for preparing our patients for the evening: helping them brush their teeth and wash their hands and faces, rubbing their backs, and straightening out their beds. In those days we also took the flowers out of the room and put them in the hall so that they wouldn't consume the oxygen in the room that the patients needed during the night. Then we went off duty, usually around 8 o'clock or so at night.

On Wednesday we repeated the same thing, except we had foods and nutrition class. We also had an instructor from Incarnate Word come to Santa Rosa to teach

sociology. When we finished our three-year school of nursing we had credit for college chemistry, foods and nutrition, and sociology. That was our first year. In our second and third years, of course, we were the nurses providing the care. Each floor had a sister, a nun, who was a supervisor, and a lay RN [registered nurse] who was a head nurse. All of the other nurses were student nurses with the exception of private-duty nurses who were employed by individual patients during their postoperative period. This was because in those days we didn't have recovery rooms or intensive care units. Patients came directly from surgery back to their room, and the nurse had to sit with the patients. We, as student nurses, would sit with these patients for their recovery. The patients getting intravenous fluids had their arms on arm boards to keep them out straight so they wouldn't bend them. We sat there as student nurses holding those arms to be sure they didn't move them. Today, when I see patients running around the hospital ward with intravenous lines connected and all kinds of tubes, I think back to the hours that we sat there to be sure that patients didn't move their arms and the needle didn't come out. We had to monitor the rate of the solution going in because they were supposed to have a certain number of drops a minute and we had to count those drops.

In our second and our third year, we got into the clinical specialty areas. We had pediatrics and operating room and obstetrics [OB]. We also had what was equivalent to public health nursing. We worked in the outpatient clinics and went out with the public health nurses into the community here in San Antonio. That was, at that time, very progressive for a hospital school of nursing.

MAJ Gurney: Do you remember any particularly memorable events of your student life?

BG Dunlap: Good or bad?

MAJ Gurney: All of the above.

BG Dunlap: We led a very restricted life in nurses' quarters during the school year. We could not leave the campus, except on Saturday night. We could stay out until 9 o'clock Saturday, and on Sunday we could stay up until 10 o'clock. We didn't get off duty until 8 o'clock, sometimes 7 or 8, so you know how much time we could stay out. Then during the summer we could also be off-campus on Wednesday evenings but would have to be in by 9 o'clock. Being red-blooded American women, we did everything we could to alleviate some of the restrictions that we had in that situation.

For example, there was a little Mexican restaurant on the corner down from the hospital. We would order food sent over to us, which we weren't supposed to do. We would lower a basket with the money in it from a back side of the building during the time that the guard patrolling our nurses' quarters was on the front side. They'd put the food in it and we'd bring it up and we'd have food to eat.

It was in late 1940 or early '41 that we went from two 12-hour shifts to three 8-hour shifts. Then, when we got off at 11 o'clock at night, the guard would go

down with us to the dining room where there would be some kind of midnight supper for us. Then he'd take us through the tunnel that connected the hospital and the nurses' quarters and after we got into the nurses' quarters, the door to the tunnel would be locked. Well, after working eight hours, we were not ready to go to sleep right away. You don't just turn it off and go get into bed and go to sleep, particularly if you were our age. But we weren't supposed to have our lights on. We were only allowed to have our lights on 30 minutes after we got to the nurses' quarters, and then after that it had to be lights out. We would sneak those little hot plates from Central Materiel into our rooms and extend the sheets out over the bed and put a light under the sheets. Then we'd toast marshmallows or popcorn. We would do all kinds of cooking like that under the sheets with no lights showing.

We also liked to torment our keepers. Right behind the nurses' quarters was a little settlement of Mexicans. Their tiny houses had tin roofs. We'd go up on the roof of our nurses' quarters after the housemother had made her last rounds. From there we would throw pebbles to the top of those tin roofs and get the biggest charge out of hearing them hit the roofs and go rolling down.

MAJ Gurney: Oh no!

BG Dunlap: Yes, isn't that terrible? But that helped relieve some of the stress and tensions that we were experiencing working with our sick patients. We were involved in all kinds of life-and-death emergencies, which we hadn't been exposed to prior to going into nurses' training.

We began as probies, probationers. That's what they called women just starting their nursing training program. Our housemother was a nurse. Her name was Penny, Miss Pendergrass. We used to equate Penny with Sairey Gamp, the early image of the nurse, but Penny was really good to us although we didn't think so at the time. We had our first instruction from her. She took us down to the nursing arts classroom and we took turns being the patient. We learned to put a patient on the bedpan, take them off, learned how to make a bed, to give a bath, all those basic nursing procedures.

Our first day, Adele Borchers and I reported to Third Main. As we got off the elevator, there stood Miss Mahoney and Miss Rodriguez and we reported in. Miss Rodriguez was a tiny little thing that stood there like a first sergeant, and she directed Adele to go to that end of the floor and start preparing the patients for breakfast while I was to go to the other. I didn't know where Third Main ended and Third Annex began, so I just kind of looked at the difference in the floor covering. I thought, this must be the old, and that's the new. I began at that point then, fixing up patients for breakfast.

We also had more formal classes in nursing arts after we got into working. We had classes in anatomy and physiology. All of our nursing courses were taught by nursing instructors in the school of nursing. We'd be on duty, go off for class, and return to duty. We had cardiology, pediatrics, and some other courses taught by physicians.

We also had, since this was a Catholic school, a course in religion taught by Father Burns. He really was such a tremendous person. When World War II started, he went into the Army Air Corps as a chaplain. Most of us in our class were Protestants, but Father Burns didn't try to teach Catholicism. We studied the Ten Commandments. I can see him now handing out test papers and saying "charity, charity, charity," as far as the grades were concerned. When Father Burns went into the military, Father Waters came from another one of the seminaries here in San Antonio to be our teacher. Well, he taught Catholicism. Those of us who were Protestants resented that. We were fortunate that at that time in our career we were working obstetrics or the operating room. We would manage to get ourselves scrubbed up at the time we were supposed to be in class and therefore we would be excused from religion class because we were scrubbed in. So we could always manage.

We had good nurse instructors. We really were taught the very basics of nursing, of caring, of service. I think we also got as much of the scientific approach to nursing as was taught at that time in any hospital school of nursing. Santa Rosa and Incarnate Word have always been very progressive in nursing education, as they are today.

THE WAR BEGINS

MAJ Gurney: As you were entering your last year of school, what were you hearing about events in Europe? What is it that made you decide that you wanted to go into the service when you completed school?

BG Dunlap: On Pearl Harbor Day, December 7, 1941, I was on the 3-to-11 shift. When I went on duty, I had not heard about Pearl Harbor. The patients were saying, "Oh isn't that terrible?" as they were listening to their radios. I didn't know what they were talking about. They said, "Pearl Harbor has been bombed!" War was declared. We, the students, were thinking from that point on that maybe they needed us and they'd curtail our three years and let us out of nursing school early. But they didn't need us that badly. We stayed for our full three years. Naturally, we began hearing about war activities on the radio and reading about it in the newspapers.

San Antonio was a real military town. We began to have a buildup of troops here at Fort Sam Houston. Randolph Field was Army Air Corps. That's where the cadets went for pilot training. Kelly Field was where many of the planes were being repaired and maintained. With the buildup of military people in our city of San Antonio, of course we began to date. I shouldn't say we began to date because we weren't supposed to date when we were in nurses' training, but we began to see some of the cadets when we went to church and different places in town.

At that point, really, it was the newspaper's account of what was happening, I guess, that had the greatest impact on me. I decided that I wanted to go into the military. In San Antonio we had a very active American Red Cross. The Red Cross was recruiting for the Army Nurse Corps. We didn't have Army Nurses

recruiting then. Charlotte Buckner, who had been an Army Nurse and was retired, was the daughter of a General Buckner. Charlotte worked with the American Red Cross. The Red Cross established a recruiting program called Army Student Nurse Reserve. Now someplace among my souvenirs is my tiny Army Student Nurse Reserve pin, which is kind of like one of our little ribbons that we wear on our uniform. It's blue and white with a little red cross in it. Charlotte came out to talk with us at our school of nursing in our senior year. If you were interested in going into the Army, the Red Cross had you fill out some forms and you could go ahead and have a physical and have the paperwork done, but it was not a commitment. If you did not want to go in after you finished nursing school, you didn't have to.

I decided I wanted to go into the Army because by that time some of the nurses who had graduated the year ahead of me, and had been my "cap" nurses, had gone into the Army at Brooke General Hospital. It was known at Brooke General Hospital that if you were a graduate of Santa Rosa you didn't have trouble getting into the Army. We had a large number of Santa Rosa graduates right out there at Brooke General Hospital. (First-year students were known as probies; junior and senior students were "cap" nurses. They'd been "capped." They coached, and in a small way supervised the more junior nurses. The hospital only had sisters as supervisors, civilian nurses as head nurses, and then the rest of the staff were students. We worked alongside the "cap" nurses to give the patient care.)

I almost didn't get in. I couldn't pass my urine test. I have thought about this very often. There are different points in your career when maybe some small thing might have terminated your career in the military. I was doing my training in the operating room. I'd be scrubbed up all day and then I'd get off duty, get on the bus, and go out to Brooke General Hospital to give my urine specimen. The specific gravity would be too high or too low. The next day I would take fluids according to what the specific gravity had been the day before, and then I'd go out for another urine test. I had more trouble trying to get my specific gravity so that I could be accepted into the Army.

But I finally passed that test and received word that I was to report to Brooke General Hospital on the 16th of November 1942. I finished my nurses' training just nine days prior to that, and I had indicated I wanted to go right in. So I received orders then to report right out there to Brooke General Hospital.

MAJ Gurney: Were there many girls in your class who came into the service at that time?

BG Dunlap: No, not at that time. I was the only one. Now, later on as the war progressed, some came into the Army Air Corps, some into the Army, and some into the Navy. But I was the only one out of my class reporting to Brooke at this time. Of course I found a large number of Santa Rosa graduates I already knew stationed at Brooke. They had taken me as a "probie" and saw to it that I started off right. They were responsible for a great deal of my nursing skills.

Introduction to the Army

I reported to Brooke General Hospital on the 16th of November 1942. San Antonio is my home so my mother came with me. I think she thought she was taking her little girl to the end of the world. At that time the chief nurse's office, her personnel office, and all that she was responsible for was in the nurses' quarters at Reid Hall. I reported there. Captain Elizabeth Harding, the chief nurse, walked with Mother and me across to the main hospital. The annexes we have now were troop barracks at that time. We walked to the adjutant's office in the hospital where I took my oath of office.

SPLINTER VILLAGE

Then we went to quarters. I was assigned to Quarters Seven in Splinter Village. We had cantonment-type nurses' quarters, seven of them. Three were double-deckers and four were single story buildings. My room had a bed, a bedside table, a desk, a straight chair, a floor lamp, and a dresser. The closet was a box that was turned with the back to the door and the front of the box was open. You could put a curtain across it if you wanted to but that was your closet. We had a community bath and community living room in those quarters.

Mother left me. I'm sure she didn't know what had possessed her daughter to want to go into this life. She was proud, proud that I would do that, but I'm sure she had misgivings as all mothers and fathers do when their first daughter leaves home. It was especially hard because it was wartime. They did not know what would happen. She couldn't help but have some reservations about that.

They did not issue our uniforms at that time, so I was told to report to duty the next day on Ward 9 in the white uniform that I had worn at Santa Rosa. They gave me an Army cap that I could wear. When I got back to my quarters that evening, I met some of my friends from Santa Rosa. They said, "Where are you going to work tomorrow? We hope you don't have to go up on Ward 9. That head nurse up there is good, but oh, she's strict, she's rough. Where are you going to work?" I said, "Ward 9." We even had preference statements, not like the ones you have today, but they asked me where I would like to work. Having just finished working in the operating room at Santa Rosa, I asked for either the operating room or obstetrics.

FIRST ASSIGNMENT

Ward 9 was not operating room or obstetrics. It was medicine. At that time, it was the gastroenterology ward. The troops had been on maneuvers in Louisiana, the famous Louisiana maneuvers. They had given them the yellow-fever shots, and some of the troops had developed hepatitis. So we had a large number of hepatitis patients there. We also had patients with gastric ulcers, anything that you would have on a gastrointestinal ward. It was a rude awakening to me because, as a student nurse, we weren't allowed to insert any of the tubes to do gastric analy-

ses or anything like that. But I soon learned how to do that, as we had many of these patients to take care of. Of course, I was on Ward 9 with that strict head nurse. I think maybe that was a good way to start out in the Army.

In those days we worked 12-hour shifts. When we worked night duty, we worked night duty a month at a time. We had one day off a month and when we came off night duty, we had our day to sleep and that was our day off for that month. So then the next day we went on day duty. It was a little different than it is today in nursing.

MAJ Gurney: That's right. Although some of the nurses still feel that they only have that one day off. After you came in then, was the Army what you expected it would be?

BG Dunlap: I really didn't know what to expect. I came right out of nurses' training and had not done any nursing yet. I came into the Army to win the war. I planned to go back to Santa Rosa after the war. Sister Bernice, who was the operating room supervisor, had made me promise that when I came back from the war and got out of the Army, I'd come back and work in the operating room as a civilian nurse. Every time I came home on leave after that, she'd say, "Are you back?" Needless to say, 33 years later when I came back I didn't go to work in the operating room at Santa Rosa.

I really didn't have expectations of what nursing would be like in the Army. Army nursing was an entirely different system naturally, because we had ward officers, RNs, and corpsmen giving the patient care. The RNs were giving the patient care just as I did as a student nurse. That wasn't too different, except that in the Army we were expected to do more. Many of the things that we weren't allowed to do as student nurses, we were expected to do in the Army hospital. We didn't have the many, many doctors coming around like we had as student nurses. We had a ward officer and the other doctors assigned to the ward. We really worked together as a team.

We lived in nurses' quarters so that really wasn't too different from living in nurses' quarters as students, except we had more freedom than we had as student nurses. But even then, we had to be in by midnight. The nurses' quarters doors were locked at midnight, and we had a nurse on duty in the chief nurse's office. She made rounds in the nurses' quarters to make sure there was no hanky-panky going on. She then locked the doors at midnight. So there were still restrictions, even at that time.

As far as the nursing care itself, at Brooke we had very few dependents. Most of the patients were troops. We had one ward for the women, one for obstetrics, one for pediatrics. I didn't work on those wards at that time. I was on Ward 9. I came in November 16th and went on duty the 17th. At that time, hospital units were being activated to be shipped overseas. One of the famous units being activated here at Brooke was the Baylor Unit from Baylor University. The activation process included actually organizing the unit, getting them outfitted with uniforms, getting their equipment, and so forth so that their unit could be shipped

overseas. Some units did leave directly from Brooke to go to the port of embarkation.

I wanted to go overseas. So I went into the chief nurse's office and signed a piece of paper volunteering for overseas. My friends from Santa Rosa who had already been in a year said, "You'll never make it because we have been trying to get into a unit to go overseas and there are so many volunteers everybody wants to go. You're going to be low man on the totem pole." Within a month, my name was on a list to join the 59th Station Hospital. That was December 15th.

Preparing To Deploy Overseas

59TH STATION HOSPITAL

In March of 1943, 23 Army Nurses from Brooke, all second lieutenants with the exception of one first lieutenant, met in the lobby of Reid Hall. This was the nurses' quarters. It was 2:30 in the morning. We were being shipped overseas in a secret troop movement. We couldn't even tell our families what time we were leaving. The chief nurse, Captain Harding, came down in her bathrobe to say farewell to us. She kissed us each good-bye just like a mother saying good-bye to her daughters. We boarded the bus and went down to the Southern Pacific Railroad and boarded the train. The train pulled out then in the early morning hours bound for Indio, California.

The 59th Station Hospital was assigned its own APO number. We thought we were going to India at that APO, but instead we were off-loaded at Indio, California. There we boarded ambulances and moved way out into the desert to an armor division training center. The chief nurse, who came from Fort Benning, and 6 other Army Nurses who came from LaGuardia Hospital in New Orleans joined the 23 nurses from Fort Sam Houston. These 30 nurses became the 59th Station Hospital. The enlisted men and the male officers had activated at Camp Grueber, Oklahoma, and they joined us for the formal activation of the 59th Station Hospital at Camp Young, California.

MAJ Gurney: How much of that facility was a reserve facility? Were the personnel out of active units or were there reserve personnel who joined you?

BG Dunlap: We didn't have reserves as such. All of the nurses were direct AUS [Army of the United States] temporary appointments. Some other hospital units were activated around the medical schools, like the Vanderbilt Unit, the Baylor Unit, and so forth, but they didn't belong to the reserves at that time.

MAJ Gurney: Did most of the physician officers come from one hospital then?

BG Dunlap: If they were with the Baylor Unit or another like it they did. I just recently had a donation sent for our Army Medical Department Museum from

Lieutenant Colonel Elizabeth Hannah, Harrodsburg, Kentucky. She was a member of the Vanderbilt Unit out of Tennessee. She sent a memorial in for the commanding officer and the chief nurse of the Vanderbilt Unit. But that's the way so many of the units were activated, around a medical school or a hospital. The nurses and the physicians came from that one facility.

CAMP YOUNG, CALIFORNIA

Our unit was not that way. Our unit was unique in that it was the first unit to activate and function as a hospital while still in CONUS [continental United States]. Most of the other units would activate and then ship out. But we activated at Camp Young, California, and we operated a tent hospital in the desert providing medical care for the troops who were in training maneuvers out there or who were with the tank divisions to be shipped out for the European theater.

We started with a tent hospital with no air conditioning in that hot California desert. When the sun went down at night, then it got terribly cold. Later they built us one of those "tarpape" hospitals that had some air conditioning units on their roofs. We called it "tarpape" because its outer covering was tarpaper. We moved in and actually operated a hospital, providing the medical care for the troops out there in the desert.

MAJ Gurney: You talked a little bit about getting the "tarpape" hospital together. What was it like to get that ready to take patients?

Team Building

BG Dunlap: This was a unique experience because it was how the members of the 59th Station Hospital, officer and enlisted, learned to work together as a team. The orthopedic surgeon and the head nurse of the orthopedic ward and the non-commissioned officer [NCO] of the orthopedic ward were a team. No matter where the unit was, the three of them were the ones to set up that particular orthopedic ward. Or it might have been the surgical ward, or other different wards. The tarpape hospital was like any incomplete building. It had the little paper stickers on the walls. The steel cots, blankets, and everything else were still packed. The doctors, the corpsmen, and the nurses all worked together unpacking, washing windows, and setting up our ward. We worked together as a unit within a unit. The operating room nurses worked to set up the operating room with the surgeons working with them. As our unit stayed together, we continued to do that.

I was the orthopedic nurse and I worked with Dr. [Captain] John Q. Brown (Johnnie Q). He was an orthopedic surgeon from Columbus, Ohio. I visited him when I was Chief of the Corps. I was in Columbus as a guest of Ruby Martin's hospital unit. She got in touch with Johnnie Q, and he and his wife came out for the banquet that evening. It was such a delightful surprise to be able to see him after all those many years.

Working together as a unit this way served us well later. For instance, on the Admiralty Islands, patients came in and the doctor would do what we think of as

triage. Then it would be up to the wardmaster and me to see to it that the patients had X-rays and were ready for surgery according to the priorities he set. Dr. Brown went into surgery and started working. We learned to function well as a unit, and I think our success was based on the good start that we got.

The people in our unit came from a variety of backgrounds. Our physicians all came to us from civilian life. Our commanding officer had not been practicing medicine, per se. He had been working with a surgical instrument company as a consultant. But we had tremendous physicians. I think they were some of the best in the country. Our enlisted men were mostly from the Texas area as were the 23 Army Nurses who left from Brooke. Our Chief Wardmaster, Sergeant Bill Green, was from Odessa, Texas. He had worked in the oilfields before coming into the service. The Army gave him the basic medic training set up rapidly to give new medics some basic aidman skills. He really treated this bunch of young second lieutenant nurses almost like a father. Truly, he did. He looked after us.

I can remember another medic, Sergeant Keener, who was from Louisiana. Did he love that hot sauce! He talked like he was from Louisiana, too. The orthopedic sergeant was Sergeant Treadway. We worked together whether we were setting up our hospitals or getting large numbers of patients in. We worked until the patients all got to surgery and back to the wards or they were otherwise taken care of, whichever they most needed.

CAMP CHAFFEE, ARKANSAS

Training

I said our unit was unique, and let me talk more about what we did. We activated at Camp Young, California. We stayed out there almost six months in the desert. Then we traveled by troop train back to Camp Chaffee, Arkansas, for four months of jungle maneuvers. There we went on half-day duty in the hospital. The rest of the day we were with our unit for unit training in preparation for going overseas. We went on overnight bivouacs and road marches. On these overnight bivouacs, we'd set up our own tents and would have to be responsible for the camouflage and the trenching around our little pup tent. Of course, during the night they'd always have to let out some tear gas so we would have to practice putting our gas masks on. We didn't just have the gas mask drill where we went through a gas chamber. The alert would wake us up, and we'd get our gas mask on real quick before the tear gas got down to our area.

More Team Building

We were a young group. Our chief nurse was in her 30s. I was the youngest one in the unit, both in service and in age. In 1943, I was 21. So our nurses ranged from 21 to whatever, Molly [First Lieutenant Troxell] was in her 30s. We were a very live wire, active group. We'd been in the desert together and on maneuvers, and already we had developed that esprit de corps that a group develops when you go through good times and bad times, fun times and sad times together. We worked hard, but we liked to have a lot of fun, too.

We didn't have automobiles at Camp Chaffee and it was about 12 miles from Camp Chaffee to Fort Smith. We would get on the old rickety bus and ride into Fort Smith, Arkansas. There we'd buy the biggest, juiciest watermelons we could get and carry back on that bus. Then we'd chill them in the refrigerator and have a watermelon party out on the lawn between the quarters. Well, the permanent party people at Chaffee looked down their noses at us, this bunch of young, good-for-nothings out there having fun. We had a good time together, doing things like that, just sitting out there having a watermelon party on the ground between nurses' quarters.

MAJ Gurney: That's right, that's great.

BG Dunlap: We had good times together as a unit.

MAJ Gurney: Do you think that those kinds of activities contributed to everybody's ability to cope later, when they were overseas?

BG Dunlap: Absolutely. We developed it as a unit, both while working in the States and while riding troop trains cross-country.

MAJ Gurney: Tell me about the soldiers you worked with as you were preparing to go. The soldiers were pretty much young boys, weren't they?

BG Dunlap: Yes, the soldiers were young. Of course, we were young too. So, we were peers to a lot of them. A lot of them were younger than we were. A lot of them were older, too. But overall, they were young. Most were draftees. There weren't many volunteers so there was a draft. There were some of those who had been in the old Army and, naturally, they're the ones that moved ahead to become wardmasters and supply sergeants. They took more of a leadership role. That's why we keep stressing training during peacetime because the people we have today are the ones who are going to be our key people when we have to expand and take in this large number of people from civilian life.

The soldiers were mostly youngsters. They had all levels of educational preparation. Some of our corporals, our privates, even had Ph.D's. They were from all sections of the country. Our patients were also a cross-section of our country. There were all socio-economic and educational levels of people. It was quite an experience for nurses as young as we were. It brought us together to take care of, and work with, people we may otherwise have never met.

I've said this often. In World War II we didn't know when the war was going to end. When we were sent someplace, we didn't have a set period of time that we knew we were going to be there. We were sent, period. Just as I indicated, we were leaving San Francisco in '43 and saying "Golden Gate in '48." This was because we went over to win the war, and nobody had any idea how long the war was going to last. Well, we developed a closeness for survival. We helped each other to cope with whatever we might encounter during that time. Whereas during Vietnam, the tour of duty was one year. You went over for one year and then you came back.

There was a constant turnover during that one year. I really don't know how much of that same closeness, like we had, can be developed in one year. I know some, yes, but not to the degree that we developed it during World War II.

It's been of interest to me just recently while talking with Colonel Hannah. She was a member of the Vanderbilt Unit. They had a reunion of the Vanderbilt Unit recently. The enlisted men of the unit initiated this reunion. The Camp Zama group was the medical command in Japan at the beginning of Vietnam before they had a medical command over there. Their enlisted men also initiated a reunion. We have our RANCA [Retired Army Nurse Corps Association]. Some of us who were World War II veterans founded this organization. We at first intended it to be an association for retirees, but there were so many other Army Nurses who served in World War II. They may have been in for only one, two, or three years, but they felt the closeness to the group from World War II and they wanted to be members. That is why we provided for associate membership, so they could still be in the group since we served together in World War II. It's an interesting phenomenon.

The unit then left Camp Chaffee, Arkansas, by troop train to travel back across the country to Camp Stoneman. We stayed at Camp Stoneman just long enough to be out-processed. I don't remember the exact number of days. They gave us wool uniforms at Camp Stoneman, really appropriate for our trip to the jungles. There the chief nurse also subjected us all to "inspection" for bugs. We marched down from the staging area to be taken by a little ship up to the docks where we were going to sail for the Pacific. We'd had desert training and we'd had jungle training. The unit was going to Australia. We boarded the USS *West Point* and sailed on Thanksgiving Day, 1943. As we left, we all said "Golden Gate in '48." We hoped we'd be back to see the Golden Gate Bridge in 1948.

TRAINING

MAJ Gurney: I want to stop on a thought that you generated when you talked about all the training that you got. At that time, wasn't it unusual for units, and especially nurses, to get any kind of training?

BG Dunlap: We did not have a basic training for nurses when we came into the Army. That wasn't started until 1943. So it was the responsibility of the unit to provide the training for the personnel. Our unit was very much aware of the fact that we were going overseas and that we needed to know map reading. We needed to be physically fit. We also needed to know field sanitation and chemical warfare. Our training even included calisthenics and some drill. I guess it was because we had such good leadership in the unit that we naturally felt we wanted to be the best and we wanted to be prepared. We didn't know what we were going to get into. So we trained, and worked at the same time.

UNIFORMS

MAJ Gurney: Describe your uniforms during this period. What kind of uniforms did you have?

BG Dunlap: When I came into the Army, I had the white uniform. I think they were worn in World War I maybe, that old white uniform.

MAJ Gurney: That's very close to the same thing. I think the last specifications prior to your first year were 1923.

BG Dunlap: It had sleeves and a white cap. That was a hospital uniform. We had to be in uniform all the time. We couldn't wear civilian clothes. One of our uniforms was in two shades of blue. It had a teal blue skirt with a navy blue jacket. The jacket had a maroon stripe on the cuff of the sleeve. We were issued white shirts and blue shirts. The little blue visor hat was kind of flat on top. We wore black shoes with that uniform, and they issued us a blue cape with a maroon lining. It was a beautiful cape. We also had a navy blue sweater, a blue muffler, and gray gloves to wear with the uniform. I guess that was it when I came in.

But then when we joined the unit and were going to be shipped overseas, we packed all our white uniforms and left those here in the States. We were then issued a blue—between a flag- and a blue-bonnet-blue—dress. This was a long-sleeved, seersucker dress with white buttons, a white cap, and we wore our white hose and white shoes with that, as long as we were here in the States. Out in the desert, we wore those. At Camp Chaffee, we wore the seersucker. Then when we got to Stoneman, we were issued that olive drab uniform, the wool two-piece uniform that replaced the two-color blue. We were going to the Pacific, so you know we really needed that wool uniform!

MAJ Gurney: Oh, that's right.

BG Dunlap: We were not issued any fatigues or field equipment at all.

MAJ Gurney: I was thinking that there was no utility uniform that you could use for heavy duty work.

BG Dunlap: No. We took our blue seersucker uniforms over with us because that was the overseas uniform. They did wear that seersucker uniform in the European theater. I understand some wore them over there, but we couldn't wear them because when we got to New Guinea we had to wear slacks and shirts with long sleeves to protect us. We had to keep our sleeves down all the time unless we were giving a bath. We could roll up our sleeves during some procedures, but when we finished we had to put our sleeves back down. We had the slacks that we wore and the Li'l Abners [named for a comic-strip character], the high-top shoes. But we didn't have those when we got to New Guinea. After all, we weren't supposed to go to New Guinea. We were supposed to go to Australia. Our ship had 10,000 troops aboard, many of whom were amphibious engineers. They needed those engineers up in New Guinea right away so they diverted our ship three days out of Australia and sent us right on to New Guinea. If we had gone to Australia, we would have been given some field uniforms—slacks and things like that to wear.

But we didn't go to Australia; we landed in New Guinea at Milne Bay. We immediately went to the quartermaster to buy men's clothing. I wear a size 5 shoe. There are not many men who wear a boot in a woman's size 5. Also men's slacks aren't cut to the proportion that women need. Even so, that's what we bought, the shirts, the field uniforms that the men had, and men's boots. Then later on, we were issued a khaki type slack and shirt, and the Li'l Abners.

When we dressed up, we wore the white or blue shirts that went with the uniform with two shades of blue. We could wear those blue ones on duty with the khaki slacks or we could wear the khaki shirt that we had.

We often did our laundry down in the river behind our hospital in New Guinea. When we wanted to starch those shirts, we stopped by the mess hall and got cornstarch. We particularly most wanted to starch the white ones, because that's what we wore when we got "gussied up." We wore that white shirt with the khaki slacks. Sometimes too we'd starch and iron the blue shirts so that we would really be dressed up.

In Australia, they had developed a khaki culotte. We were able to get some of those culottes. They were what we wore to play softball and to do some of those athletic things. But our uniform was the khaki slack and either the blue or the khaki shirt and the Li'l Abners. For malaria control, at sundown we went over to our quarters, put our mosquito net down around our cots, and sprayed. Then we put on our leggings and tucked in the bottom of our trousers. We'd take our mosquito repellent and put it around our necks and on ourselves.

We had an outdoor theater where we sat on bomb racks or coconut logs. If we were going courting that night to the outdoor theater, instead of giving us a ticket as we went in, we put our hands out and they'd put insect repellent in them. We rubbed the repellent around our necks. Can't you imagine courting smelling like insect repellent? But everybody else did it too.

MAJ Gurney: That's right, everybody had the same kind of perfume.

BG Dunlap: But that was part of the malaria control that we had to abide by. Our patients had similar procedures. At sundown, we tucked the mosquito nets down around the end of the patient's bed. This created some problems when we were doing procedures during the night because we had to lift up the mosquito nets.

MAJ Gurney: Tell me about your experience at Chaffee related to the uniform you were to wear on duty.

BG Dunlap: We had been out at Indio and had worn the blue seersucker uniforms with the white hose, white shoes, and white hat. We had already sent our white uniforms home because we were going overseas. Then when we reported for duty at Camp Chaffee, the chief nurse there told us we would have to wear the white duty uniform. Our chief nurse told her that we didn't have white uniforms or the Class A uniform. We had sent them home just like people who had cars had sent those home. We'd sent everything home because we were going overseas. The

Chaffee chief nurse said then that we couldn't go on duty in those blue uniforms. We'd have to have white uniforms. Our chief nurse said she was not going to make us go buy white uniforms to be on duty there at Chaffee. She was a first lieutenant. The chief nurse at Chaffee was a captain. But our chief nurse stood up to that captain. She said, "My nurses go on duty in blue uniforms or they don't go on duty." We went on duty in blue uniforms.

MAJ Gurney: When you said, "Golden Gate in '48," this was in '43. That seems like a rather gloomy prediction. Did you really feel that it was going to be that long before you saw the United States again?

BG Dunlap: We had no idea. But we didn't intend it to be gloomy. It was hope. We were saying, "We hope this is over, and we see the Golden Gate in '48." We meant it in a positive sense as opposed to negative.

Deployment

THE *WEST POINT*

The *West Point* was headed for Australia because the medical units going to the Pacific were sent to Australia for staging before being sent on to the different islands. The *West Point* was a very fast ship. We made it in 16 days to Milne Bay, New Guinea.

MAJ Gurney: Tell me about the troop ship and the trip over on the ship. You said you made it very quickly, in 16 days.

BG Dunlap: The *West Point* was a luxury liner, the USS *America* in peacetime. Like so many of the luxury liners, it had been converted to a troop ship. A cabin for two had been converted into a cabin for seven. I was one of seven in an inside cabin, so we didn't have a porthole or any view outside. We had a shower in that cabin. The water was turned on only for a short period of time and everybody had to get in and try to complete his or her showers in that time. We had one nurse in our cabin who wasn't a favorite of ours. We were always tormenting her because she tried to boss us around. Another one of the nurses had some plantar's warts on her foot. We kept talking about how infectious those were. So with all that, this one nurse wouldn't get in the shower. That cut it down to only six of us to use the shower. She used the washbasin.

There were 10,000 troops aboard that ship. I felt sorry for the enlisted men; they really didn't get to come up on deck except to smoke. It was terribly crowded for them down there below deck.

We had two meals a day—a breakfast and an evening meal. We'd have to stand in line a long, long time for each meal and try to fit the shower in between the meals. The nurses in our unit were fortunate though because some of our enlisted men were doing KP [kitchen police] aboard the ship and on the serving line. They

would see to it that we got a little more than the normal serving as we came through the line. Here they were, even taking care of us in a situation like that.

The 16 days seemed to go so fast because with seven people in a room you had to move really fast. We'd get up in the morning, get in line, get to breakfast, and come back and clean up. Of course, we had lifeboat drills all the time too. Then we'd have to put our life jackets on. The next thing we knew it'd be almost time to start getting in line again for our evening meal. We played a lot of canasta, and did a lot of talking. The 16 days went fast.

MAJ Gurney: Did they run a hospital on the ship?

BG Dunlap: They had a sick bay, but we didn't work in there. The Navy took care of that. We asked if we could help, but no, we couldn't. I was thinking about Chaffee. There, working in the hospital was an experience because there were a large number of patients who didn't want to go overseas. I'm sure you've read in the history of the war that old term we used, "gold bricken'." There were some GIs who were scared or for various reasons didn't want to go. This was difficult for me. I had to learn to work with this type of patient. They were primarily on the GI [gastrointestinal] wards. They'd complain of symptoms of ulcers or weight loss and try to be discharged from the service to save themselves from having to go overseas. Some ate and then they'd go to the bathroom and poke their fingers down their throats and vomit. We watched them very closely because we knew that they must be getting food someplace. They'd go over to the PX or get some of their buddies to go in and buy milk shakes and then they would manage to hide from us and drink a milk shake. One of the other famous complaints was back pain. Then a person wouldn't be able to carry the heavy pack and gear.

But this was quite an experience for me as a young nurse because all the nurses were volunteers. These men had been drafted and they didn't want to be in. They were trying to get out and not have to go overseas. It really taught us an awful lot of patience. At that time we were beginning to get some patients back who had been overseas. We took care of those who had served and been wounded, and then we had wards with some of these others. It was very difficult to accept. I was so naive. I really couldn't believe that anyone would do anything like that to keep from going overseas. I guess maybe that's when the art of nursing really came into play because we learned how to deal with people like this and still treat them professionally. Sometimes you certainly didn't want to.

I didn't find that, once I got overseas. It's an entirely different situation there. Once in the overseas area, the patients were taking care of each other. We'd have patients, I can see them now, a patient in a body cast from the waist up, the old airplane splint, and he might be pushing the wheelchair of an amputee. They took care of each other, so it was an entirely different environment.

MAJ Gurney: What do you think contributed to that? What gave them a different attitude? Is there a feeling of camaraderie among the patients when they get overseas? Perhaps it was a kind of a relief to the soldier to know they've gotten

through what could have been the event that ended their life. They've gotten through it and now they want to help a few others make it, too.

BG Dunlap: Yes, it was a beautiful experience.

Awareness of POWs

MAJ Gurney: At the time you were getting ready to go overseas, and in the first, well, year and a half almost, were you aware that some nurses were being held prisoner in the Philippines by the Japanese?

BG Dunlap: Not so much until we were heading for the Pacific. When we were heading for the Pacific, then what we had been hearing impressed us that much more. Truthfully, I never thought about being taken prisoner. I used to say I got where I did because I was so stupid I didn't know otherwise. Perhaps it was self-confidence. I was really taking a chance. Maybe I wasn't as prepared as I should have been. But it didn't enter my mind that I couldn't do it. I thought, I can do that. Throughout my career I always thought that. With the help of the dear Lord and a lot of patient, good chief nurses, I "did it" most of the time. So, really, when I went overseas, the nurses in our unit didn't think in terms of being captured or being prisoners. We then became aware that there were nurses who were prisoners over there in the Philippines. We were way down there in New Guinea and they kept repeating the slogan, General MacArthur's, "I will return." Well, we did our own takeoffs on that too. We'd say, "We will return." And, "Mac needs us to return." But our hero from here was General Krueger, Walter Krueger, because he came from Fort Sam Houston. We kept saying "Walter sent for us"—the nurses from Fort Sam—so we could go over there and help him win that war. But we didn't dwell on the fact that there were nurses as POWs, no. We were too busy.

MAJ Gurney: You were too busy taking care of patients and having a good time too when you could squeeze it in.

NEW GUINEA

BG Dunlap: Then when we got to New Guinea we did not set up at Milne Bay as the 59th Station Hospital. They already had a hospital. Therefore they farmed us out to the hospitals that they had there at Milne Bay. When we got to New Guinea, they weren't expecting us. They moved the male officers out of a coconut grove that had thatched huts in it and moved the nurses into that area. They put our male officers and our enlisted men on all kinds of details other than medical details, working with engineers and everybody else. The hospitals there were really just a thatched hut with most of them built on the ground. Surgery and its related areas had floors and so forth, but the hospital wards were just on the ground with the cots set up on the ground with the thatched roof over the top. The ambulances came in the morning and picked up the nurses and took us around to the

different hospitals to work. Then they brought us home in the evening. As I indicated, we weren't working as a 59th Station Hospital.

First Christmas

We spent our first Christmas overseas in that environment, because we landed on December 8th, I think it was, 1943. Can you imagine spending Christmas in a coconut grove? We were a little bit homesick, no Christmas presents or anything like that. The chaplain of a unit just across the road from us had one of those old record players that you had to wind. He had some Christmas records, so we could hear Christmas carols. What were we going to do for Christmas? I met a Signal Corps officer aboard the ship, and he was in New Guinea there at Milne Bay for a while. He came up to see me and brought me a Christmas gift. It was a flashlight he bought at the PX. I was one of the few who had a flashlight then to use as we went back to the "six-holer" [latrine].

We didn't have the turkey and all the trimmings for Christmas Day, but being a bunch of Texans and people from this part of this country, we liked great big, white, sweet onions. Our mess sergeant was able to get some white, sweet onions. Also, he got some fresh baked bread, and my tent mate had been able to bring a bottle of champagne rolled up in her bedroll overseas, so we used our canteen cups to sip champagne. We had fresh bread and sweet onions to celebrate Christmas.

MAJ Gurney: Oh my gosh.

BG Dunlap: Merry Christmas. We had Christmas carols in the jungles of New Guinea. We only stayed there a short time because they then took us by a hospital ship up to Oro Bay, where we went inland to Dobodura.

Earlier, we talked about how we worked hard to take care of patients, but played hard when we could squeeze it in. So many people have asked me about M*A*S*H, as I'm sure they've asked you. I tell them that I can relate to M*A*S*H beautifully. I think the story of M*A*S*H is that when there is work to be done, everybody pitches in and works around the clock until the work's all done. On the show they make it more dramatic and bloody than some of the situations we were in, but, in many ways, it was the same. There's a group of people brought from all sections of the country. All these individuals come together as a unit. They work and work and work, and during the lull they played. We played. You have to do something to relieve the stress and to help you cope with what you're going through. One of the best ways to do it is through physical activity, softball. I think in M*A*S*H they had a football game.

World War II Field Hospital

When we were in New Guinea, we only stayed down in Milne Bay a short time, and then they sent the nurses on a hospital ship up to Dobodura Hospital. Dobodura was a 1,000-bed hospital. You'll be interested in the configuration of this 1,000-bed hospital. There were ten wards of 100 patients each. The wards were in the shape of a cross, so we had four wings. Each wing had 25 patients. The

tarpaper siding of the hospital went about halfway up so there was an opening at the bottom and an opening at the top and then the tin roof. In the center of the cross was the nursing station so that it became a square. Within that square there was a desk-like thing for the nursing station for each wing. In one corner we built shelving for supplies. In another one we set some drums for the dishes. At that time, they brought the food around in a truck and we'd go out to the truck and bring the food in. Then we had to do the dishes there, in that corner. Another corner was the utility room, where we kept our bedpans and things like that. We couldn't empty bedpans there. We had to take them down to an outhouse where they could be emptied. The fourth corner was for medicines.

We had 10 of these wards built in a semi-circle. Then in front of that we had an enclosed building for the surgery, X-ray, laboratory, headquarters, dental clinic, and supply. We also had a mess hall in the shape of a cross: one room for the officers, one for the enlisted, one for the patients, and, finally, the wing for cooking.

We were at the 363d Station Hospital at Dobodura. Dobodura was near an airstrip, which served the P-38s and P-39s flying from that airstrip. The hospital was that 1,000-bed hospital out in the jungle that I just described. I've often thought, in constructing our hospitals today, how efficient that configuration was, because during the daytime we had one nurse and one corpsman for each wing of 25 patients. Now, those were battle casualties of course, a surgical ward. Otherwise, on the medical ward they had all kinds of things from that terrible jungle. We also had a psychiatric ward too. During the day the ward also had a head nurse and a wardmaster who were at the control point, the center of the ward. During the night we only had one corpsman and one nurse for those 100 patients. But the nurse was at the center of the cross and could see each wing.

Our hospital was divided into the different clinical specialties as any hospital would be. I can remember Ward 10 at the far right end was genitourinary, and psychiatry (Ward 1) was at the far left end. The different medical wards were on the left. The surgical wards were on the right. Also on the right we had officers' wards. All the officers, regardless of what their condition was, were on one ward. Since it was four 25-bed wards, we could separate the medical and the surgical patients. I can't remember when it was we stopped having officers' wards.

MAJ Gurney: I remember we still had them at Walter Reed in '73.

BG Dunlap: Well, in '71 when I was chief out there, I know we had the officer ward. Eliminating the officer wards was a real change in Army care. We always had the officer ward and some people wanted to work on the officers' ward. Sometimes they didn't. I remember the one at Walter Reed particularly, and the problems they had down there.

Back to New Guinea. The care that was given in that hospital, nursing care, was something else. Particularly because we had very limited supplies. When I talk to youngsters today about suctioning, wall suctioning, they don't think anything about it. They have piped-in wall suctioning, and wall oxygen. We didn't have that, even in our stateside Army hospitals, in those days. But in New Guinea, we fixed

our own Wagenstein suction using empty bottles. We switched them like the Wagensteins did. If we wanted any tidal flows, we'd fix them ourselves using IV [intravenous] tubing. We didn't have plastic tubing, just rubber IV tubing that was re-autoclaved. Everything had to be used and reused.

At the hospital we didn't have our own laundry. There was a quartermaster laundry unit set up not too far from us. We ran out of clean linen so often. I can remember turning the linen, putting the top to the bottom, reversing it and turning it over. In the jungle, where they had all the rain, we couldn't get the linens dry. Well then we would just keep using the linen until we could get clean linen.

I think one thing that impressed me so much, this early in my nursing career, was the patients that we had. They were so critically ill and wounded, but they were such good patients. They didn't really complain that much. We had some complainers, but not many. This is characteristic of the care in an Army hospital; the patients took care of each other. Recall that patient in a half body cast pushing an amputee around in a wheelchair. Patients took care of each other. When they did that, naturally, we were then able to provide more care to the patients.

The medical patients were quite a challenge because they had diseases and conditions that we really didn't know too much about, particularly the dermatology patients. We didn't know that much about jungle rot. Epidermophytosis was the name of it, but they called it jungle rot then. In nurses' training we didn't see it. Our poor patients were so uncomfortable, and we really didn't know how to treat them. We'd treat one patient with boric acid packs and another one with gentian violet painted on him. A third may have carmine, the red solution. Still others would be given calamine lotion. We tried everything that we could to keep the patients comfortable. A lot of the patients had to be sedated because it was "driving them nuts." It really was. They were just frantic because they couldn't get relief from it. It was a real experience trying to treat that kind of condition in our hospital setting. We actually had to evacuate some of our dermatology patients to the States, not just because of the primary medical condition, but because of their psychological problems. As I said, it drove them nuts. You know how you get a little itching from something, a mosquito bite or something, and it really just annoys you. You can imagine your whole body being in discomfort like that. They were quite a challenge to take care of. We also had patients with dengue fever, malaria, hepatitis, and scrub typhus.

MAJ Gurney: What percentage of your patients were hospitalized for those medical conditions in comparison to your combat casualties?

BG Dunlap: You see, we considered them all combat casualties.

MAJ Gurney: But if you isolated the surgical wounds from battle from those not battle-injured—

BG Dunlap: Well, I was trying to think about that the other evening after we talked. I know that all the Wards 7, 8, 9, and 10 were surgical. Six was the officer

ward. I can't remember, but at least three or four of them were medical wards. It was almost half and half. This was really necessary because we just had so many of the fevers and the dysenteries. Approximately 30 percent of Army hospital cases were malaria.

The 11th Airborne came into New Guinea. They brought the jumpers and gliders, but soon found out that you can't use gliders in the jungles. So they had to retrain the glider troops to be jumpers. These soldiers only had to have three jumps to qualify as a jumper. We found out that if they were jumping that day we'd turn down the beds and get ready for patients.

We had what they are referring to as combat fatigue. And so much of it truly was combat fatigue. I can remember one night when I was covering two medical wards. I was down on the psychiatric ward. The patients slept on steel cots with the mosquito nets around them. That night, I was making rounds with the corpsman when we heard a jeep, or some vehicle, backfire. One of the patients heard it in his sleep and awakened thinking it was gunfire. Well, he was trying to get out to get under the bed. I'm 5'2" and I didn't weigh very much in those days. He was kind of caught in the mosquito net and halfway off the bed. I just went over and picked him up and rolled him back into bed, on his cot, like that. Afterwards I thought, how in the world did I get that big man back up on that bed? But such things as that would frighten the patients because they'd been up in combat and heard those sounds.

It was quite a challenge to take care of those medical patients, in particular, for another reason. Because just like it is today, you get the surgical patients in the hospital, they have surgery, they're cured, and they go home. But not the medical patients. They become chronic care patients. I'll talk about patient evacuation, how slow it was. We had many of those patients for months and months under those conditions. It truly was quite a clinical experience for a young nurse. All of us in our unit were young nurses. There were few who had been in nursing for any period of time.

MAJ Gurney: Did you have any patient category systems, a means of separating them according to the severity of their condition? If you had several patients that were recovering from minor illnesses, did you set them apart? Did you put the most severely injured together, or change the nurse-patient ratio in certain instances?

BG Dunlap: Well, we didn't have recovery rooms. We didn't have intensive care units. But what we did was put the sickest patients nearer the nursing station and those less ill, a greater distance from the nursing station. Remember there were 25 beds to a wing so the beds nearest the nurse's station in each of the four wings would be where we had our sickest patients. They needed closer attention. We had to group these patients, because we just had one nurse and one corpsman taking care of the 100 patients during the night. But we didn't have categorization of patients according to nursing care needs like we know it today. That actually developed in the Army in 1949, 1950, as a result of the Valley Forge studies.

Unit Organization

I wanted to describe the organization of the unit before we move on. We had a chief nurse, for instance the 363d Station Hospital chief nurse was Captain Francis Cecil Gunn, who later was in The Surgeon General's Office. The different units then would come to be put on DS [detached service] so that the nurses from the 59th Station Hospital, my unit, were on detached service there. Molly Troxell, who was a first lieutenant, was our chief nurse. There was another unit of nurses on detached service there, and I think Captain Margaret Brannon was the chief nurse of that unit. So we had a number of nurses from different units on detached service staffing the hospital. The chief nurse of the particular parent hospital was the chief nurse of the total operation, and the other chief nurses served as supervisors, or assistant chief nurses, something like that.

Captain Gunn (Colonel Gunn later in her career) was a tremendous chief nurse. She was later my chief nurse in Germany in the 1950s, about '55. She was truly a nursing leader and was able to meld together the people from all these different units as a nursing service so that we didn't have any of those jealousies about who gets more day duty than night duty than the others do and what not. That didn't exist. We really became the 363d Station Hospital Nursing Unit—until we got on the baseball diamond.

MAJ Gurney: Oh, yes?

BG Dunlap: Our 59th Station Hospital nurses were baseball players. Ours was a women's baseball team, naturally. All of us from the different units came together to form the baseball team.

MAJ Gurney: How many nurses were in that composite of units?

BG Dunlap: I don't know. I can't remember. I know in our unit we had 30 nurses. I'm assuming that maybe some of the other smaller units on detached service might have been 30 nurses or so, but the 363d Station Hospital was larger.

MAJ Gurney: You may have had 100, 150, or 200?

BG Dunlap: Oh, at least. No, not 200. I think it would be near 100.

I showed you a picture of our quarters. They looked like stables. If we were on night duty, we slept in one of those rooms and heard all kinds of noises and everything else going on. So finally they built a night nurses' hut down at the back side of the compound. It was a great big thatched hut for all the night nurses to go down there and sleep to get away from the noise and activity of the compound. But they had a fire down there and it burned down. It hadn't been rebuilt when we left to go on up to the Admiralty Islands.

ADMIRALTY ISLANDS

MAJ Gurney: When did you go up to the Admiralty Islands?

BG Dunlap: The 16th of September 1944, we were relieved of temporary duty from the 363d Station Hospital and placed on special duty over at the 108th Station Hospital, right near Dobodura. That was because they needed some nurses over there. Captain Janet H. Froome was the principal chief nurse of the 108th Station Hospital. So we reported in the 16th of September 1944, helped for only two months, and departed there the 15th of November 1944. At that point we flew up to the Admiralty Islands and rejoined our 59th Station Hospital.

Our officer and enlisted personnel actually set up and we functioned there as a station hospital. It was the only hospital there on that particular island, Los Negros Island. This hospital was a tent hospital on a coral island with sand that was coral sand. That sand was our floor. We didn't have wooden floors in the tents. We just had the tents pitched on that sand along one long walkway with tents on either side. Once again, we had the surgical tents nearer the front of the hospital and the medical tents at the other end of the hospital. The medical and surgical units were always divided like that. I mentioned that I was an orthopedic nurse. Therefore our tent, the main orthopedic tent, was the second tent on the right. This was because surgery, laboratory, headquarters, and all were just up ahead of us, so that when surgical patients had to go to surgery they'd come right back to our nearby wards. Remember, we didn't have recovery wards and the recovering patients were then nearer the surgery. If we ran into any problems, they could be moved back up to surgery in a hurry.

I can't remember how many patients we had in each ward, but I think we had 15 steel cots on either side. Our nursing station just consisted of a field desk at the front of the ward. I don't know what the field desks look like today, but it was just a table with folding legs. We made our own file cabinets out of boxes we got from supply. The water for the ward was kept in jerry cans, jeep cans, outside our ward. In the back of the ward, they had the bedpan rack hanging outside. The bedpans and anything else had to be taken down to a central latrine to be emptied. We didn't have running water and we didn't have toilet facilities on the wards. The ambulatory patients had to go down to the six- or eight-holer with the burlap around it.

The 59th Station Hospital nurses' quarters were thatched huts, two to a hut. It had the thatched roof and thatched sides. The thatch on the sides was high enough so no one could see in. The nurses' huts were right on the cliff overlooking the water. I say cliff because it was all coral. I think I showed you some pictures. I was down swimming and we had one of those little rubber rafts, but we had to wear tennis shoes because we could get coral cuts walking on the coral.

We had a thatched hut for an officers' recreation hall. That would be in the center, and the nurse tents were on one side and the male officers were on the other side. We had the recreational hut that we could share.

Officer Status

MAJ Gurney: Let me ask you some questions about your status as an officer. We are talking about November 1944. At the time that you entered, the Army had only relative rank for nurses. Were you aware of any attempts to get Army Nurses full commissions as officers?

BG Dunlap: We didn't know the difference. We had only two or three nurses who had been in the Army before the war. We considered them "Regular Army" because the rest of us had come in for wartime. Beyond that, we were not aware of any real differences among officers.

I think I prefaced our interview with the fact that I was sort of pushed ahead throughout my career. The units during World War II had TO&Es [Tables of Organization and Equipment] and the TO&E for our hospital, the 59th Station Hospital, called for a first lieutenant as chief nurse, a first lieutenant as her assistant, and the rest of us were second lieutenants. We would be second lieutenants as long as we were in that unit. That's why our chief nurse, who was with us for a while after we were at the 363d, transferred out of our unit. She became a captain by moving into a station hospital larger than ours.

The 2nd of February 1945, I was promoted from second lieutenant to first lieutenant. Well, what happened—remember, we just had two first lieutenants in our unit and I was the youngest one in age and service. Another one of the nurses, who was what we referred to as the Regular Army nurse, and myself were the two who were promoted from second to first lieutenant. Some of the older nurses resented that. How did this upstart get to be promoted from second to first lieutenant? Well, I didn't know how I got to be promoted from second to first lieutenant, but I didn't question it. I accepted it. Some of them really didn't talk to me for quite a while because they were hurt that they hadn't been promoted and I had been promoted ahead of them.

Then we had a new problem. What is a chief nurse going to do with two new first lieutenants, now, in the unit? She wanted them to show increased responsibility with the increase in the rank. Therefore she made me the surgical supervisor, and the other nurse, [First Lieutenant] Ruth Crowell, was made the medical supervisor. Well, again, think about the position I was in. There was no resentment toward Ruth because they recognized that she was a senior person. But there was resentment toward me, selected to supervise some of them who certainly had much more experience in nursing, and in the military, than I had. Even though I was a supervisor, I still had to run my orthopedic ward too. It was my responsibility to check on the surgical wards and to report to the chief nurse. It wasn't just a supervisor position.

But as far as any promotions, we felt that we were not going to get any promotions unless we got out of that unit. I'll kind of jump ahead a little bit. I had been in for three years when I came back from overseas. I entered the Army in November of '42 and I got back to the States in November of '45. I came back as a first lieutenant. Some of us went back to work then with nurses who had been promoted to first lieutenant in less time, only 18 months. We came back to work at Brooke as first lieutenants with 3 and 4 years' service and were first lieutenants working with those who'd been in 18 months and hadn't gone overseas, but they outranked us. We became more aware of these differences when we got back here to the States.

In our unit we didn't really think about rank that much until those first two promotions came through and then, naturally, they wanted other promotions to come through.

We had an acting chief nurse, [First Lieutenant] Margaret Taczey, after our chief nurse, Molly Troxell, transferred out. She served as the acting chief when we moved on up to the Admiralties and until the new chief nurse, Margaret Cronin, came in. She was a captain. So we had a captain as a chief nurse through the rest of the time that we were overseas.

We were so isolated in the Pacific. We really didn't know, or care, what was going on back in the States. I shouldn't say we didn't care, but we were busy. We were working hard, and we just didn't really know a whole lot of what was going on, even over in the European theater. We had the *Stars and Stripes*. Actually, we could get radio sometimes. Plus we got letters from the States. But mail didn't come very often. Even so, we were busy and concerned most about what we were doing.

Treatments and Medications

I'd like to describe more of the treatments and medications that we used. In those days we gave a lot of sulpha, which was administered every four hours. The penicillin was a powdered concoction and had to be mixed up at the time we gave it. In other words, we couldn't mix it up in the morning for all the dosages we were going to give during the day. We had to mix it up just before we were going to give it. The powder and mixing solution had to be kept over in the laboratory. So the corpsman would go over to the laboratory and get the penicillin and we'd sit there and mix it up. We'd then draw up our syringes for the dosage we were going to give and fix up our tray with our penicillin. The corpsman would take a water pitcher and those envelope paper cups and the sulpha pills. The two of us would go around to the cots and we'd tap on the mosquito net. We used to laugh, because they'd stick a hand out for the sulpha and stick out their rear end where we'd poke it to give the penicillin. Then we'd go on to the next patient. So you can imagine what it was like each time the penicillins were given, some as often as every three or four hours. We were constantly mixing penicillins and getting our sulpha ready to give to the patients. They began to get some penicillin in the beeswax that was longer lasting. We'd only have to give that twice a day. But we didn't have much of that. The sulphas and penicillin were about all we had. Of course, there was atabrine for malaria and aspirin.

In addition to that we were busy doing dressings. I can remember our experience at Tacloban. We'd come on duty—this again was one long ward and one nurse covering two wards, maybe even covering 200 patients or so. We came on duty, and the dressing cart would be perhaps halfway down the ward. That's as far as they had gotten that day with changing dressings. So we'd start from that point, changing dressings and doing treatments that still needed to be done.

I saw my first gangrene in the Admiralties. Some of the Marines who had been on Cape Gloucester were sent down to us. They had received immediate medical care—morphine, bandages, and all—on the beaches, and then they were put on landing craft and sent down to us. Some of them had gangrene. They had received the antitoxin but it was outdated. Also, I saw my first scrub typhus. There is so much kunai grass up in Cape Gloucester that the sharp edges of the kunai

grass cut the soldiers. The little mites had gotten into them. We saw scrub typhus and the malarias and, of course, hepatitis.

Patient Evacuation

We also had a lot of amputees, orthopedic patients, and neurosurgical patients. We did not have a means for quick evacuation of the patients. There was no scheduled evacuation. Sometimes we heard that there was a ship coming in. It took supplies on up ahead of us and it was coming back and was able to take out some patients to Australia. Well, naturally we tried to get the most critical patients we had, like the paraplegics, out. But some of the patients stayed for months before we could get them on a hospital ship to get them out to Australia. All of the transportation that they had was needed to get troops and supplies up and to bring casualties back as soon as they could. It was quite a challenge for nursing.

MAJ Gurney: Was there any air evacuation at all? When you evacuated patients, how did they go? Did you evacuate most of your patients by ship or plane?

BG Dunlap: There was no evacuation, as we know it now.

MAJ Gurney: But there was some early use of flight nurses and air evacuation during World War II. They didn't get down to the New Guinea area?

BG Dunlap: Not in that area. I think they were up around Hollandia, maybe Finschhafen, but not into our area. We had to depend on the ships coming into the bay there. Those ships took the patients on down to Australia.

We didn't evacuate many patients. We'd get the word that a ship would be coming in at Oro Bay and so many patients would be going out. They'd take them down to the ship. Sometimes we'd get word that a plane was going down to Australia so they'd be able to take some of the patients down to Australia. Patients stayed in Australia a long period of time, actually, before they could be evacuated back to the States. When the word came in that there was a ship going to come into Oro Bay, that was big excitement. That was back down in New Guinea. Up in the Admiralties we had some ships come in, and they evacuated some by air back down to Australia.

Just a short distance from Los Negros was Manus [Island] where there was the big Navy hospital. Manus was where they had a big floating repair dock so that they could bring the ships in there and repair them rather than having to take them back to Pearl Harbor for repair. So patients could be evacuated on the hospital ship after we got up on Los Negros, but we just didn't have much rapid and systematic evacuation in New Guinea.

"Tex"

I must tell you about one of my patients. You always want to know about some memorable event. I'll never forget one Marine. The Marines wanted to be recognized as Marines, so they wore their Marine overseas cap so you wouldn't mistake

them for an Army soldier. One particular Marine had lost both legs, one arm, and had received a head injury. He couldn't talk. Also, his wounds had maggots in them. That was the first time I'd seen that. But he was such a tremendous patient. He was on my wing and I took care of him for a long, long time. I indicated earlier that we played a lot of softball. The nurses played against the officers, against the enlisted men, and others. We'd take the patients out to watch us. They'd go in wheelchairs, or we'd take them on litters. Even this Marine went out to the games. We put paraplegics in the ambulances and then backed the ambulances up to the diamond so that they could be propped up and could watch. Of course, the patients the next day kidded us about "swinging like a rusty gate" and about how we ran and dropped the flies. We'd been out playing baseball one afternoon after work; remember we were doing 12-hour duty.

MAJ Gurney: That's right, and you still had the energy to play softball.

BG Dunlap: Oh yes. The next morning, we were having change of shift report in the center section and one of the corpsmen came to me and said this patient wanted to see me. I said, "Can you tell him we're having report? Can he wait just a few minutes and I'll be down there?" The corpsman came back and said; "He wants you right now." So I excused myself and I went right down there. He said, "Hi, Tex." Being from Texas, you know, I was Tex. But those were the first words he spoke to us—"Hi, Tex."

Well, all the patients knew what he was up to. He had been able to say something, but he couldn't carry on a complete conversation. They were just dying for me to get on duty that morning so that I could find out about it. How could anyone ever forget something like that?

Innovations

MAJ Gurney: Do you remember any innovations that you used that may have helped you through this experience?

BG Dunlap: One of the biggest gains we made was in self-confidence. Remember, nine days after I got out of nurses' training, I went right into the Army. That was November '42. I was at Brooke General Hospital until March of '43 when I went with the unit into the desert. From there we were thrown into New Guinea. I guess maybe outwardly I have never lacked for self-confidence. I've always approached a job as if, well, I can do it. There's a job and I can do it. But I'm sure that during that year down in New Guinea, I began to develop confidence in my nursing care. This was largely because the patients that we saw there were not the appendectomies that we saw in the hospitals where we trained or some of the other stateside hospitals.

Naturally, we improvised all the time. I'm trying to think of some specific examples. There in the Admiralties, on the orthopedic ward where we had amputees, we got in a group of patients. I'm thinking they came from a nearby island. These were infantrymen who developed limb gas gangrene. We thought it

was possibly because the serum they had been given was defective, outdated or something, but we had a whole ward of gas gangrene patients. I really had to learn how to take care of this kind of patient. We'd never taken care of this type of patient before. So the nurses and doctors worked together. How do we provide the care for this patient? Naturally, they were isolated. We used gown and glove technique. They were in such terrible, terrible pain. We had to change and dispose of the dressings and so forth. That was quite an experience, taking care of those patients.

Christmas in the Admiralties

I've got to tell you about the Christmas back on the Admiralty Islands. I was in the Army 33 years. I spent six Christmases overseas—three in Germany, one in Okinawa, one in the Admiralties, and one in New Guinea. Naturally, Christmas is the time that you best remember.

Christmas in the Admiralties: remember, we got there in November. I've already described the hospital. What were we to do for Christmas? What could we do for a Christmas tree? We had to have a Christmas tree for Christmas. Well, we managed. Our corpsman, bless him, he was wonderful. He managed to find some trees there that were like sticks and he cut limbs off. We could tie them on to shape it like a Christmas tree. What do we do for Christmas decorations? Remember our laboratory slips? There was a red one for blood, pink for hematology, yellow for urinalysis, and a pale green for gastric analysis. We had all those different colors. Well we sat there and cut little strips of those blank lab slips and used flour-and-water paste to make paper chains. We decorated with that. Also there were little balsa wood balls washing up on the shore. We gathered a lot of those and we fastened those on to the tree with some kind of adhesive tape. So, we had our decorated Christmas trees.

What could we do for the patients? Our mosquito nets were the olive drab mosquito nets, but the Navy had white mosquito nets. How could we get white mosquito nets? I think I mentioned that no women could go over to Manus Island. There were no Navy Nurses over there. The hospital was run by their corpsmen, and the commodore wouldn't let any women on the island. But the Navy officers came over to our island and socialized, you know. We've got some really fine Navy officers. And, of course, our enlisted men had contact with some of the enlisted Navy. It was known that the Army Nurses wanted some of those white mosquito nets. So there was a little bit of exchanging and bartering going on and we got the white mosquito nets. We cut those mosquito nets into the shape of Christmas stockings, sewed them up and we got red flannel bandages for ties.

Then, what were we going to put in them for gifts? Well, we had some fruit that we got from the mess hall. Some of the men on the island had organized an assembly food pickup and they brought food. The Red Cross helped us also with razors and different things like that. We got some cigars that we could put in the stockings.

We were doing all this secretly. The patients didn't know what we were doing. So after they went to sleep that night and the lights went out, we went around and

we tied the stocking with the red flannel bandage at the foot of each bed. When they woke up the next morning Santa Claus had come and left them a stocking. I still get a thrill even thinking about it because it was such an experience to be able to do that for them. You asked, were we innovative? We surely were. We were determined that we were going to have as much Christmas as we could for the patients. But we got more good out of it than they did.

I mentioned also that we had a lot of Texans and people from Louisiana. Here in Texas we like pinto beans. My mama sent me the dry pinto beans. Our mess sergeant managed to get us some old bone so that we could cook up our pinto beans over in the nurses' area. We took over the hot plates and put a big pot of pinto beans on and cooked them all day. We soaked them overnight and cooked them the next day. Then they also sent us some cornmeal so we could get the mess sergeant to fix up some cornbread for us. Our enlisted men somehow found some fresh onions somewhere. There's nothing better than pinto beans, cornbread and fresh onion. Whoever was off duty watched the pinto beans cook and then when they were through cooking, they got word to some of our enlisted wardmasters. They came and met us at the compound fence and we gave them pinto beans to take over to their area to eat.

On Los Negros, there was a Marine airstrip and Marine detachment. The commander was a colonel and the Marines were set up like the Navy. They had Quonset huts. Their dining room was a Quonset hut. The tables had white tablecloths and they had black mess boys. The Marines could fly to Australia and get supplies, so they had many of the fresh supplies that we didn't have. They managed to get an ice cream-making machine and when they went to Australia, they got the powdered milk and ice cream mix and they could then make ice cream. Sometimes they invited us to come down and have a meal in their dining room. They knew we liked apple pie, and I can still see Colonel Mount sending his driver with fresh baked apple pies up to the nurses at the hospital. We met out at the recreation hut and brought in all these apple pies they sent up to us. They took really good care of us. Oh, there are so many things to talk about.

THE PHILIPPINES

MAJ Gurney: From the Admiralties, where did you go?

BG Dunlap: We were there from November '44 until the 12th of April of '45. We went from there on up to the Philippines. Our male officers and enlisted personnel flew up there with all of our hospital equipment the last of March or April of '45. In the interim, they sent the nurses over to the Navy base on Manus and we were attached to the Navy Base Hospital #15, just for rations and quarters. We were just there five days. We departed the 17th of April '45 from Manus and we arrived in the Philippines the 25th of April and were assigned to the 133d General Hospital for temporary duty. Again, it was only the nurses of our unit assigned there. Captain Margaret Cronin was still the chief nurse of our 59th Station Hospital, but the chief nurse of the 133d General Hospital was Major Eileen

Brady. Eileen Brady later was in The Surgeon General's Office as chief of Personnel. But at this time she was the principal chief nurse of the 133d General Hospital. The nurses then stayed at the 133d General Hospital from the 27th of May 1945 to the 31st of May 1945, when we were assigned back to our 59th Station Hospital. We went down to Cebu and again joined our men and set up our own 59th Station Hospital in Cebu.

Cebu was the name of the island down there, and that is where we set up our own hospital. That was an interesting experience. I was talking to a lady recently who had been a POW in Santo Tomas and her home had been in Cebu. She visited Cebu recently. I was telling her how it was when I was there. Of course, bombs destroyed everything. But the capital was on Cebu. The capitol building was at the end of a large, long boulevard. Going up that boulevard on the left there was a library and that had been bombed out, so that it was condemned and we couldn't set up a hospital in there. We set up our hospital between the library and the capitol building.

Our nurses' quarters was just directly behind the bombed-out library. Our volleyball court was on the yard of the library. For housing in Cebu, they built a building with a tin roof, tarpaper siding, and screened it in. Our latrine of similar construction was directly behind us. We all had cots, canvas cots not steel cots. We just had our cots lined down each side with an aisle in the center. A picture shows the ironing board out there, footlockers at the foot of our beds and some chest type thing by the side. That's what we first lived in.

Later they built us a nurses' quarters which was thatched. The area was U-shaped and across the front it was U-shaped concrete slabs. It was thatched on the side and open at the top with a thatched roof. Across the base of the U was what we could use for our recreational hut. Those who played bridge played in there. We had two to each room. We had something like little stalls with our canvas cot and our dressing table made out of a packing case and we fixed our own place to hang our clothes. They also always had a fence around the nurses' quarters to make it like a compound and they had guards on it for security. We always had this security whether we were in the jungles or wherever we were.

We played volleyball, and I wanted some tennis shoes. I wrote to my mama, who was living in Miami then, and asked her for tennis shoes. She couldn't find any tennis shoes. "Don't you know there's a war going on? We don't have rubber tennis shoes, for size 5 feet anyway." I said, "But my tennis shoes are wearing out. I need some tennis shoes!" She finally found some tennis shoes and sent them to me. They were my pride and joy, those new tennis shoes. One night the Filipinos broke into our compound and came into the rooms where we were sleeping. They sneaked into our little room and stole the cosmetics—lipsticks or anything like that—and my tennis shoes. I could care less about the lipstick, but my tennis shoes were stolen. They never found whoever stole the stuff, but thereafter, anytime I went around that island in a jeep, I didn't look at the mountains or the jungles; I looked at the people's feet to see if I could see my tennis shoes. I swore up and down if I ever saw my tennis shoes on anyone, I was going to run over there and grab my tennis shoes off them and start another war. That became a joke—"watch for Dunny's tennis shoes when you go out!"

We had some fine Filipino physicians who worked down there with us, and they wanted to show their appreciation to us and entertain us at their homes. They didn't have much, but they wanted to invite us out to eat. Well, we were not supposed to eat anything outside of our compound, nothing out on the economy at all. It was pretty tempting because we'd see some of the Filipinos squatting there, frying bananas. Oh, they looked so good, but we weren't supposed to eat them. We hesitated about accepting the invitation to the Filipino doctors' homes to eat but I can remember we did it occasionally. The chief of Surgery whose name was Dr. Kissinger, the chief of Orthopedics, Dr. [Captain] Johnnie Q. Brown, and my roommate then, whose name was [Second Lieutenant] Kay Green, and I were invited to go down and have dinner with some of the Filipino doctors. We went and had a very good dinner with rice and some chicken. And we had a very nice evening. We felt we had to do it, because they wanted to show their appreciation for what we were doing for them and their people. Then, when we left and came back to the hospital, we stopped by the ward and each took a big dose of Epsom salts before we went to our quarters, just in case we'd gotten hold of something.

Our hospital had the headquarters and the surgery in a permanent structure. It was a combination metal and wooden building. We also had one great big surgical ward. It was almost like a giant warehouse made of that type of material. The rest of the hospital was set up on concrete slab with a thatched roof and open sides.

I couldn't help but remember in the film that we saw recently, "We All Came Home," the comment that Josie Nesbit made about the patient who asked her for a drink of water. She didn't give the patient a drink of water, and she has always regretted that because it wouldn't have done him any harm anyway. Well, I think about one of the patients I had that had an NG [nasogastric] tube down. Occasionally we got beer rations up from Australia, and we might be able to have one bottle of beer on the ward for each patient. Well, this young GI wanted some beer so badly but there was just no way he should have any beer. It probably wasn't good logic but I thought to myself, "Why can't I give him beer? He's got the tube down; the beer will go in and it'll come right back up through the tube. He'll enjoy the taste of it." So I gave him some beer. It just foamed and helped to irrigate the tube as it came back up, but he enjoyed the taste of the beer just like the other fellows.

Filipino Patients

We took care of Filipinos in addition to our own troops. One Sunday afternoon we got word we were getting some Filipino patients who had been attacked by the Japanese on a nearby island. They were old men and women and children. The young men were out of the village and off the island. But the Japanese attacked the village anyway, and tortured the people. We put them in the same type of ward as our quarters, with the concrete slab floor and the thatched roof. I'll never forget one tiny little malnourished girl. The Japanese had taken bamboo and run the splinters up under her fingernails. They bayoneted her in the abdomen. The people had all kinds of intestinal worms, parasites. These worms often came out through the wounds. Also, when this young girl coughed, I'd have

to reach down into her throat to help pull out some of these worms that she was coughing up so that she wouldn't choke on them. The Japanese had taken her earlobe and just whacked pieces out of that. They did that to a lot of the villagers. We had one pregnant lady. It was quite evident that she was pregnant, and they had bayoneted her in the chest and lopped off a piece of her breast. She also had a stab wound into the breast. There were all kinds of bayonet wounds and torture.

Well, the Filipino patients couldn't speak English and we couldn't speak Filipino. We started intravenous fluids and took other measures for those who had to go to surgery. They really couldn't understand that we weren't going to continue the torture because sticking the intravenous needle in them was so much like the torture. They were frightened that we were going to kill them with whatever was hanging in the bottle. We did have some Filipino nursing assistants who worked with us and we kept them quite busy interpreting for us. They explained what we were trying to do because we could see such fear and horror they had after what they had already experienced. Just when they thought they were safe, we started trying to help them, and to them this was more torture. It was quite an experience.

The islands had Filipino hospitals, but they were so overcrowded and they had very few professional people to take care of the large number of Filipino civilians who were wounded and sick. We had tents set up and we cared for most of the Filipino civilians we got in those. I remember two little youngsters who were playing when they uncovered hand grenades, which exploded. They lost all, or portions of, their hands, plus had multiple shrapnel wounds in their abdomens. We did the surgery on them, but by regulation, once they had the emergency care done at our hospital and were stabilized, we were supposed to transfer them to a civilian hospital. We weren't about to transfer those two little boys to the civilian hospital because we knew they couldn't get the care that we wanted to give them. So we kept them much longer than we really were supposed to. I can remember when we were going to have an inspection by the section people; we made the bandages on their stumps a little bit larger and put them in the beds to make them look sicker.

It was a custom that when the Filipinos were patients, their family and friends would come in and bring them food. We fed the patients but like the Japanese, they didn't really like the GI rations that we had. It happened to a lot of patients but I can remember one particular patient who had an abdominal wound. She had a nasogastric tube down and we just couldn't understand why she kept blowing up. Her abdomen would become distended. Well, what was happening was that her family brought her food and she'd eat it and then the tube would block off and she would become distended.

Japanese Prison Ward

At that hospital we also set up a 150-bed Japanese prison ward. It was the same type of building we had, but it was at the far end of our hospital area. Japanese prisoners were being evacuated down to us to add to our American troops and the Filipino civilian patients. We set up what was almost an independent hospital for them. It had to be guarded because they were prisoners of war [POWs].

There were a few Japanese doctors who took care of them, and some women who worked as nurses, but they weren't professional nurses. They told us that the women were like "camp followers" who helped take care of cooking, etc. Their POW hospital was nearly self-sufficient. We wouldn't be safe to assign a nurse there. So, the nurses made rounds down there on the different shifts always taking a corpsman with them. The POW patients received the very same surgical care as our American soldiers received. I can remember particularly orthopedics, because so many of the patients in wartime are orthopedic patients. I can remember our orthopedic surgeon, Dr. Johnnie Q. Brown, spending hours and hours doing surgery on those patients. We took care of our American patients. They had priority, naturally. But we certainly took good care of the Japanese patients.

The Japanese soldiers were in such terrible nutritional states that they'd die. They had all kinds of fevers, infestations, and everything else. We had a lot of deaths down there. We also had a delivery. One of the women was pregnant so we took down red flannel, bandages, and any kind of material that we could get. Some of the Japanese women made a layette and the woman did deliver her baby in camp. She and the baby remained down there, but they both did all right under those conditions.

When the Japanese first came in, we started to feed them the same things that we ate. The mess sergeants loaded up the chow carts just like they did for our American wards and took them down to the compound. But the Japanese wouldn't eat. They didn't want to eat our food. They wanted rice and fish. Our mess sergeant actually had to cook special meals for them. They didn't want hamburgers and french fries. By then we were beginning to get some fresh meat in, but not much. All the Japanese wanted was a great big kettle of rice brought down to them.

One thing of interest. We had to have a ditch around the tents for drainage purposes because of the heavy rain in the Philippines. Well, some of our Japanese patients in a tent at the back of the ward were frightened. We had to keep them restrained and keep a guard back there with them. We found out that the Filipino workers who were digging the trenches around for drainage purposes talked to them and told them they were digging and that they were going to bury them out there in that ditch. After we found out what was going on, we got the Japanese interpreter to come explain to them that they were safe. There were some Japanese corpsmen among the prisoners and we found a couple who could speak some English. They could communicate and translate for us.

MAJ Gurney: Were your hospitals ever inspected by the International Red Cross for the care you gave prisoners of war?

BG Dunlap: Not to my knowledge. Working out on the wards, we weren't always aware of what went on at headquarters. We had base section surgeons and base section chief nurses because we were divided into base sections. They came in from different headquarters to visit the hospitals. I'm not aware of any inspection by the Red Cross, but there could never be any complaint about the care that was given

the Japanese prisoners at our hospital or, by the same token, the care for the Filipinos.

I think that if you've talked to anyone who's been in a combat situation, they talked about how they survived on humor. We always try to find the humor in incidents. There were some really good Filipino doctors and Filipino nursing assistants working with us in our hospital there. But then there were Filipinos who were, for various reasons, stealing from us. I have to be careful in thinking of condemning them for stealing. They either were hungry, or they'd just sell the goods on the black market. Survival, I guess, was the name of the game. We had our supply tents, and the Filipinos broke into our supply tents to steal our supplies. Our guards shot at them and then we were up all night in the operating room taking care of their wounds and hospitalizing them. I used to say; "Now isn't this ironic. We're over here to help give this country freedom and they're stealing from us. We shoot them to protect our supplies and then we take care of them all night doing the surgery."

RETROSPECTIVE

Women's Army Corps

MAJ Gurney: What was your experience during the war with officers and enlisted of the Women's Army Corps [WAC]?

BG Dunlap: We did encounter WACs in New Guinea. This was during the two months we were at the 108th Station Hospital. They brought in a detachment of WACs to Oro Bay. Most were Transportation Corps. They set up a compound for them down on the beach. Naturally, those who were doing clerical work and what-not could function as intended. But those who were supposed to be the truck drivers couldn't be the truck drivers. The whole idea was to bring them in and to relieve the transportation men in the rear areas so that they could go forward. But in New Guinea, a woman couldn't travel alone. When we did our courting, we'd always have two couples at least. Men driving the vehicles had to be armed. So, because they weren't armed, the WACs couldn't function in their jobs as they were supposed to unless they had an armed soldier riding with them. That defeated the purpose.

I've often thought I wanted to talk with some WACs because I read Jeanne Holm's book in which she implied some of these difficulties, but maybe she wasn't aware of some of the things as we saw it. The WACs didn't have anything to do. They became restless. They tried to set up recreation for them down there, but it was limited. You can imagine any group, men or women, becoming disgruntled with inactivity. Then their mental health is eventually affected and we began to get some of them in with some real mental health problems. I can remember particularly one woman who was hospitalized and they had to give chlorohydrate as sedative, large doses of it. She really was a psychiatric patient and we felt that it was only because of the situation that they were in. If it had been a situation where she had to go to work all the time, where she had responsibilities, this wouldn't have happened.

Were there pregnancies down there? That's always asked. I don't remember having any pregnant WACs. Remember, we were there at the 108th just a couple of months and then we went on to the Admiralties. I remember we had to evacuate a number of them because of mental health problems. But you know that if you're going to put a group of women in an isolated area, with men who haven't seen women they could socialize with in a long time, they were bound to have some socialization. But I felt so badly for them. I thought that it was poor planning to send Transportation Corps WACs. We didn't have any hospital WACs. If they had sent medical WACs up there, we could have used them.

MAJ Gurney: Did they consider giving these soldiers other jobs?

BG Dunlap: Not to my knowledge.

MAJ Gurney: What about the WAC officers? Did you have any contact with WAC officers?

BG Dunlap: Oh, yes, because they came in with the whole detachment. But they remained at the headquarters level except perhaps when they visited their WAC soldiers in the hospital. Oro Bay was a distance from us. I remember seeing one parade. I don't know what the occasion was because we didn't have a parade field there, but there was a parade and I saw some WAC officers at that parade. That was the first contact I had with them.

MAJ Gurney: What was the attitude or the feelings between the WAC officers and the nurses?

BG Dunlap: Again, we didn't have that much contact with them. We didn't often get down to the officers' club at Base Section. When we did get down there, I don't remember ever seeing a WAC officer there. When they came to the hospital, they came to see their troops, and we treated them just as we treated any other commander coming to see their troops. So there was no conflict there. We didn't have any dealings with them over a prolonged period of time.

MAJ Gurney: Were you there at the time the WACs received their temporary commissions in the Army? The WACs received temporary commissions in the Army before the Army Nurse Corps officers were granted commissions.

BG Dunlap: We weren't aware of that. We weren't aware of it at all. Whether we were AUS or XYZ, it didn't make any difference. The majority of us came in, just as I did, to win the war, and when the war was over we'd go back home where we were going to get out. So we really weren't aware of it at that time. It made no difference to us because we had a job to do and we did it.

V-J Day

MAJ Gurney: Tell me about how you felt when you heard of the victory over Japan, V-J Day.

BG Dunlap: Whoopie, now we can go home! The policy was that we could rotate back to the States based on the number of points we had accumulated. The points were based on the length of time we'd been overseas, whether we'd been in a combat area, and other factors. Those with the most points were supposed to rotate back first. We all had way over the 60 points that we were supposed to have to rotate back, but we didn't have any replacements. We heard that they were sending some of the nurses from the European theater to the Pacific. They'd go into Manila and up to Baguio, which had been quite a resort area. We'd heard they didn't have enough places for them to work. And here we were down on Cebu—why couldn't they come down there and relieve us? This is how we interpreted it from our perspective. I didn't know what was officially happening up there. I'm sure that the chief nurse of the command knew what she was doing. She didn't need us to tell her how to do it. But we couldn't understand why they couldn't send them down to Cebu and at least start letting some nurses go home.

Finally, our commanding officer took things into his hands. He just said he was going to start sending some of the nurses and the other officers home. Our census began to drop so that some were released. I don't remember how many went out first, whether two, three, or four, or who went out first. But most of us remained. We hadn't had any replacements and we were sure the replacements would be coming in from Manila very soon. Finally, he actually let us depart ahead of our replacements who were on their way down that same day.

The Influence of Wartime Nursing

MAJ Gurney: During your assignment in the Southwest Pacific, was there ever a time that you regretted your decision to enter the Army?

BG Dunlap: No, never. None yet today either. I never regretted it. I'll say the first three years (nine months before we went overseas while we were on desert and jungle maneuvers, and two years in the Pacific) really shaped my life to follow a great deal. They influenced it professionally because my original intent was to come back, get out of the Army, and go to Santa Rosa Hospital to work in the operating room. I'd promised Sister Bernice I'd do that. If I had I would have probably been just like one nurse, Sadie Mercado, who was one year ahead of me. She stayed there, worked in the operating room, and retired a few years ago. Whenever I returned to San Antonio and saw her, she'd shake her head and say, "Oh, I should have done it. I've been here all these years." She saw all that I'd done and what she hadn't been able to do. Those first three years in wartime certainly influenced my professional career.

They also certainly influenced my educational career since I'm a hospital school of nursing graduate. When I came back from overseas, I sure didn't consider going back to school. But, having stayed in the military, I became aware of my educational needs. My supervisors and chief nurses were role models and they encouraged me to go on. Because of them, I went on to further my education and my career.

I think the wartime experience really molded me as a person at a very impressionable stage of my career, that stage of transition from student to professional

nurse. Naturally, I now am very sensitive to some things that I wouldn't be aware of if I had never gone and served under those circumstances. I think about that when I hear our POW nurses telling how they're so grateful for the least little thing. We weren't deprived like they were. But we certainly are grateful for what we have based on our experiences.

MAJ Gurney: Beyond your appreciation of these special things, what do you think you brought back from this overseas experience?

BG Dunlap: I brought back respect for individuals and an appreciation for how we depend on each other. We worked together, and when people do that they get to know each nurse as an individual. Even in retirement, we in the Army Nurse Corps continue to support each other. This fellowship is something that emerged out of the closeness developed by sharing the good times and the bad times while we were on active duty. We continue to do it in retirement.

In the military, whether we realize it or not, we develop certain administrative and leadership skills needed in the civilian community. I'm jumping on ahead to retirement, but it's basic here. We begin to develop skills. We take a nurse out of nursing training and put her under those conditions with minimum supervision and that nurse learns to do on her own. She (we had a female corps at that time) assumes responsibilities for these things. People who aren't given those opportunities don't learn to assume those responsibilities. That is just a characteristic that we all developed.

Can you imagine a nurse today, handling a ward of 100 patients with one corpsman during the night shift? We know that the care given today is much more complicated. Then, all the equipment and everything was so simple. An amputation over there was just as bad as an amputation over here, but that isn't a good example to use, probably. The equipment that we had to take care of the patients was practically nothing compared to the very sophisticated equipment we have in the hospitals today.

Even so, I don't know if a nurse with just a few months' nursing experience and one corpsman to give care could assume responsibility for 100 patients. I'm not condemning the nurse today, but having had to produce like we had to during World War II, years later, we still want to produce. I've had to slow down. I did slow down. But I think that high productivity trait is something that I developed during that time. These were characteristics basic to the way we functioned. It carried through the career and into retirement.

Would that have happened if I had not had that experience and instead had gone to work in the operating room? I question that, because I would have had a routine in the operating room. There the nurse has a schedule. He or she does a certain number of cases in the same controlled environment, day after day after day. I'm sure that I would have developed differently as an individual than I did as a result of being in the Army.

When it comes to friendships, we would have friendships whether we were overseas or not. But I think that maybe ours, developed during wartime, were

deeper friendships than those developed during peacetime. It's because we shared those unique experiences. I think we have seen that in RANCA [the Retired Army Nurse Corps Association]. It's primarily the World War II nurses who belong to RANCA and then, of course, many of the World War II nurses were also the Korean War nurses. A few of the nurses were in the Vietnam War. But the relationships established, the friendships maintained, have been real lasting friendships because of the shared experiences and the respect that we gained for our compadres. We recall, "Gosh, she was a tremendous nurse under difficult circumstances." We built a respect for our fellow officers that still exists today.

What else did I bring out of the Pacific? Malaria, I brought that out. I had a little hepatitis when I was over there too, a few things like that.

MAJ Gurney: Did you ever feel that you were personally in danger?

BG Dunlap: There are two times, and one is funny. The 11th Airborne Division came into New Guinea. They had jumpers and gliders. Well, they found out that the gliders didn't work in the jungles so they had to convert the gliders into jumpers. They were in an area quite a distance from us and during their training one afternoon, we began to have live fire come through our hospital area. We had never had that before. Well, we began to hit the floor wondering what on earth was going on. It seems they had not established a perimeter limiting the troops' training area so they were firing through our hospital. After that we surely teased the paratroopers about taking "Hill 363." Until we found out what was happening, it was a little frightening. We hadn't had that happen before.

I think the only time that we, and certainly I, personally felt fear was when we were sailing from the Admiralties to the Philippines. We were on a Navy hospital ship with the lights on and the red cross on the side of the ship. We had heard about how the hospital ship *Comfort* was sunk. We thought we were broadcasting ourselves.

We kept a positive approach to overcome or put aside the fear. We were able to bury those things that we didn't want to worry about. Someone might get homesick, lonesome, or miss things, but not to the extent that it had a real negative impact at all, because we were always busy. For instance, we didn't have fresh vegetables. We'd get our families to send us seeds and we'd plant a garden. Captain Margaret Brannon was the chief nurse of one of the units. She could grow the best carrots of anybody. We were always doing something like that to occupy our time. We worked hard. Our unit didn't sit in any staging areas, or anything like that. We worked. That's the secret.

Before we finish our interview, I want to bring out something that I feel very strongly about. When we went over, we didn't know how long we were going to be gone. We went over for the duration of the war because nurses weren't rotating back and forth. We didn't have a fixed tour. You'll remember we said, "Golden Gate in '48," hoping we'd be back by '48. But we didn't really have a rotation date to look forward to.

We went over, and returned, with an entirely different attitude than those who went over for a one-year tour, as they did in Vietnam. Then, everything was geared to coming home in one year. I saw it both ways because during Vietnam I was chief of the Army Nurse Corps Assignment Branch and I watched those nurses rotating back and forth. Every year we struggled to meet the requirements to get all of them over there. I can't help but think that the different expectations had some impact on the attitudes of the people who came out of Vietnam in contrast to the attitudes of those who came out of World War II.

I'm not smart enough, or enough of a psychologist, to analyze those things, but during World War II we were all in it together 'til it was over. When you have different people constantly coming and going on a one-year tour, enduring turnover like that, it's bound to require a different approach to manage the stress.

MAJ Gurney: What other experiences can you think of relating to the Southwest Pacific that you feel we may have missed in our discussion thus far?

Special Patients

BG Dunlap: I can't help but remember certain patients, like the soldier with double amputations or the triple amputee. I must tell you about another one. Remember, in the Admiralties we had gas gangrene. I'll never forget one young patient. He must not have been more than 18 or 19 years old. He was just a young, handsome fellow who wanted to be a doctor. He had gangrene and went to surgery to have an amputation of his arm, his right arm. I'll never forget him after surgery. We recovered him on the ward, stayed closely with him. We paid particular attention to the ones with the gangrene especially because we had no recovery rooms or intensive cares.

Normally I loved to take care of amputees, but he wanted to be a doctor. I'll never forget that patient. As he began to respond saying, "Do I have an arm? Do I have my arm? Do I still have my arm?" How could I tell him, "No you don't have an arm." But I had to tell him because our doctors were so busy. They stayed in surgery all day, made quick rounds, and then were gone in surgery again. They came back whenever they could to check on the patients. If we needed anything, we sent over to surgery to tell them and get instructions.

There are other patients along the way who are especially memorable. Particularly ones like the paratrooper who lost a leg. Oh, it was so sad. He'd sit on the side of his cot and shine both boots. Paratroopers took such pride in those shined boots. He was just a youngster and he had a high amputation. I've got pictures of him, sitting on the side of his cot, shining both boots. He knew he was never going to be a paratrooper again. But the soldiers never said that they knew. They'd always demonstrate the faith and hope that they always would.

MAJ Gurney: Did the tragedy of the destruction of war on those young patients ever get to you?

BG Dunlap: Naturally, it got to us. Particularly because we couldn't evacuate patients. We had another patient there in New Guinea on our ward who was

paraplegic due to a spinal injury. I mentioned him before, I think. It bothered us so to actually just see him rotting away. We didn't close those wounds, we packed them with the Iodofoam gauze, and then we let them heal from the inside out. He didn't have the nourishment that he should have laying in the hot climate like that.

We'd just be sick, sick, to think, why can't we get these patients out of here and do more for them, get them evacuated on down to Australia? But those patients challenged us, if I may use that word *challenge*. At the time we didn't think of it as a challenge. What could we do for the patient's physical and his mental condition too? The patient with the spinal injury is the one I mentioned that we put on the canvas litter and took out to the ball diamond to watch us play baseball. We were able to prop him up a little bit so he could watch us play softball out there. We'd do anything like that we could do, to give any of them a boost.

Special People and Experiences

MAJ Gurney: During the World War II period, were there any people, either nurses, physicians or anyone who you feel were particularly memorable? Perhaps for some reason or another they really stand out during that period of time. Maybe you either learned from them or they were mentors or peers, or something like that.

BG Dunlap: I'm trying to think. Of course, we had the chief nurse of our unit, as I explained to you, Molly Troxell, who I went over with. When our unit went on detached service to the 363d Station Hospital and Francis Cecil Gunn was chief nurse of that hospital, we had all these separate units in there on detached service. I think I learned a great deal from Cecil Gunn, just by the example that she set. Also, there was another individual who was the head nurse of Ward 10, which was the urology ward, Lucy Jacobson. She was a first lieutenant, and I used to say, I've told her many times, my ambition was to get to be a first lieutenant just like Lucy.

MAJ Gurney: What is it that these people did that was so meaningful that you felt you learned from them?

BG Dunlap: Well, from Cecil Gunn there was great dignity, compassion, skill in administering a nursing service with about four different units in there on detached service. Each unit had their own chief nurses, their operating nurses, nurse anesthetist, their whole staff. You know how we have a tendency to kind of stick together as a unit.

She was able, and did it so beautifully, to really mold a nursing service out of those different groups. I felt that although I was with the 59th Station Hospital, she was my chief nurse. We didn't have the jealousies about taking time out, who's going to get to be charge nurse, or whether one group had to work more night duty than day duty. We just felt that we were one nursing service and, of course, the more I thought of her over the years, the more appreciation I have for what she did to achieve that.

MAJ Gurney: Certainly, later as Chief of the Corps, you would have to have those same characteristics, same traits. When you have a lot of polarized units, you need to be the singular head.

BG Dunlap: Well, I think this applies at stations such as Brooke, where you have reserve, National Guard, many different groups coming into the hospital all the time. The reserves bring their chief nurse in and their NCOs and so forth. You certainly have to be able to make them feel, while they're on duty in that hospital, that they are a part of that hospital and that nursing service. I hate to use equal opportunity, that's been an overplayed term, but they really are equals.

But I think I really learned that from Cecil Gunn. Later on, she was chief nurse at Neubruecke, Germany, 98th General Hospital, when I was over there. She pinned my major's leaves on. She demonstrated those same skills over there. I just had the greatest respect for her as an individual, for the way she handled her staff and her relationships with her patients and the physicians.

MAJ Gurney: And Lucy Jacobson?

BG Dunlap: Lucy Jacobson. I'm trying to think. She became chief nurse of different hospitals along the way and then in 1959 to '60, when I went out to Fitzsimons to do my residency in hospital administration, she was the assistant chief nurse out there to Lieutenant Colonel [Alice] Gritsavage. She later retired. I don't remember what her other assignments were.

MAJ Gurney: What was it that you feel you picked up from her, that you drew from her?

BG Dunlap: Well, her value was at the ward level. I explained that each ward had 100 patients on it, and I saw how Lucy managed her ward of GU [genito-urinary] patients down there. GU patients aren't always the easiest patients, and urologists are not always the easiest physicians to work with. Sometimes the language in a setting like that was not always what I expected, and I saw how she ran a beautiful ward despite that. Her patients got good care. It was great leadership and the physicians, her patients, and her staff respected her too. She cracked the whip but also had a great sense of humor. You towed the mark when you worked for Lucy. You learned from her. I saw her at RANCA several times and we've exchanged Christmas cards.

MAJ Gurney: Who were the other persons of particular note who perhaps gave you something that you carry with you now?

BG Dunlap: There were certain experiences that had that effect. In our unit, the 59th Station Hospital, we were all peers. As I said, I was the unit's youngest nurse in age and service, but as professionals we were peers. Each one of us was in charge of our own ward. We were also peers in skill levels and experience. I had a little less experience but I learned orthopedic nursing by doing it.

The assistant chief nurse, [First Lieutenant] Lucille Grace, was the supervisor of the whole hospital. Her brother was Judge Grace; he lives here in San Antonio. I can't remember that she had much impact on my development during that time.

I think I may have mentioned promotions. The chief nurse was a captain, the assistant chief nurse and the OR [operating room] supervisor were first lieutenants, and everybody else was a second lieutenant. Two first lieutenant promotions came through. One went to Ruth Crowell, who was a Regular Army Nurse, and the other to me. Those nurses more senior to me resented that. They were disappointed. Why did the youngest one get the promotion when only two came through? That was quite a learning experience right there for me. We had lived and worked together all those years in very close quarters. Two or three of the nurses completely ignored me. They wanted to have nothing to do with me over in the nurses' quarters area because they were so disappointed and took it out on me. Although they didn't have anything against me as an individual, they just couldn't understand why I should get the promotion and they didn't get it.

The chief nurse made Ruth a supervisor of the medical section and I became supervisor of the surgical section. In addition, we each remained charge nurse for our tents. That's what we were using then as wards. I found that I really had to step lightly and establish my own parameters for what I thought supervision was. I wasn't going to be supervising them, per se. I was going to be making rounds to see if there was anything that I could do to help them, depending on the workload. I would need to see if I could switch someone from one place to another, adjusting for the workload. That was a learning experience.

MAJ Gurney: A sobering experience.

BG Dunlap: It was. I think I mentioned to you, before we started recording, that I've had a number of these same experiences in my life. I was frequently the youngest one in age and service when I was promoted over somebody and put into a top position.

MAJ Gurney: Earlier, we discussed the commissioned status of nurses during World War II. Before the officers of the ANC were granted temporary commissions were you addressed as "Miss" or by your rank?

BG Dunlap: By my rank.

MAJ Gurney: You were called by your rank while you were over there? Many nurses report that up until the time when they got their temporary commissions, they were still called Miss.

BG Dunlap: No, in our unit they always called us by our rank. We didn't have the fatherly, old Regular Army types, in our unit. Our physicians had all come in during World War II and got out at the end of the war so we didn't have that. Now, if I had been stationed at a general hospital where we had a commander who was

from the old Army, he might have called his nurses "Miss." But in our unit they did not.

MAJ Gurney: That's good. Everyone came in under the new circumstances and they fell into line much quicker.

Redeployment

They flew us from Cebu up to Manila. There was a big staging area up there where all of the nurses went to be processed to come back to the States. I don't remember how long we stayed there in Manila, but it wasn't too long. We boarded one of the Liberty ships, the *Marine Jumper*. I refer to it as a bathtub out in the ocean because it was one of those Kaiser Liberty ships built quickly for the war effort. It was a tiny little thing. On the *Marine Jumper*, we didn't work. We played a lot of canasta. The seas were very rough during our trip back. We arrived in San Pedro, California, on Thanksgiving Day, 1945. That was such a coincidence because we had sailed on Thanksgiving Day going over. Because we crossed the dateline, we celebrated Thanksgiving on the ship.

CAMP ANZA, CALIFORNIA

Then, after we got into San Pedro they put us on a troop train and took us to Camp Anza. We just froze. November in San Francisco, or the San Pedro area, is quite a shock after coming from the jungles. Oh, we froze. We were sitting in that troop train waiting to go on to Camp Anza and I can remember the Red Cross coming along the outside of the train with coffee in paper cups with red crosses on them. I don't drink coffee, never did, but I'd say "I'll take the cup, thank you," and I'd take it and I'd hold it in my hands to keep them warm. When my buddies finished drinking their cup, they could have my cup of coffee. Then I'd take another cup to hold.

We got to Camp Anza late that night, and they took us to our barracks with its double-deck bunk beds and then took us to the mess hall to eat. They had German prisoners there who were running the mess. This was the first time we'd ever seen German POWs. But they had the most delicious Thanksgiving dinner saved for us, even at that late hour. We stuffed ourselves with our second Thanksgiving dinner. The first thing we wanted to do was to get to a telephone to call our families to tell them we were home. Not all of us got through that night, but we were sure to telephone the next day to get through to them.

MAJ Gurney: Describe your transition to Army nursing stateside.

BG Dunlap: After a few days at the redistribution center we received orders to report to Fort Sam Houston to the Reception Station. We reported in on the 29th of November and were given 45 days' leave.

MAJ Gurney: Which you really didn't get because you spent it in the hospital.

BG Dunlap: Not all of it. I did have a good time. My tent-mate, hut-mate, whatever-we-lived-in-mate came here to San Antonio on leave. While she was here we had a good time together visiting and doing some things before I came down with malaria.

DEMOBILIZATION

MAJ Gurney: So then you became ill with malaria and were hospitalized for a period of time. That was during the time when the Army was massively demobilizing. Can you discuss the implications that demobilization had for Army Nurses?

BG Dunlap: What was happening was that people reported in to the Reception Station and were put on 45 days' TDY [temporary duty] for recuperation. Then, at the end of that time, the nurses often received orders discharging them. That was it. Many wanted to stay in and couldn't stay in. If you didn't want to stay in, there was no problem, you got out. While I was on that leave, I had the malaria attack and was hospitalized for a long period of time. I feel sure that if I had not become ill, I would have been one of those many thousands who demobilized right away because I was not Regular Army. I think they were more likely to keep the Regular Army Nurses.

MAJ Gurney: Do you think that was the rationale that was being used to determine who stayed and who went?

BG Dunlap: I don't know what the rationale was. If you talk with some of the Corps Chiefs who preceded me, particularly Inez Haynes and Ruby Bryant, they might be able to give you the rationale. Remember, I was a first lieutenant. I didn't know what the rationales were or what was going on up in Washington as a first lieutenant. All we knew was we got a set of orders and we complied with them. It seemed though to us that they were keeping those who had been in before the war and had certain MOS's [military occupational specialties] that they needed. They needed a certain number of OR nurses. They certainly didn't need all of the OR nurses that they had, so they would take the more senior, experienced ones. That's how it appeared. I don't know what the official rationale was. The fact was, when you have 60,000 nurses and you have to get down to a strength of, I don't know how many we got down to just after that, perhaps around 3,500, you've got to do something.

MAJ Gurney: The nurses had no part in the decision though.

BG Dunlap: As individuals, we didn't.

MAJ Gurney: Were there nurses retained on active duty who might have wanted to get out?

BG Dunlap: Not to my knowledge here at Brooke. I wasn't aware of it.

MAJ Gurney: They could ask to be released if they wanted to?

BG Dunlap: I think they could if they had been assigned overseas. There were some people who never went overseas. I don't know if someone stationed here at Brooke could have gotten out if they wanted to or not. I don't know, because we were in for the duration. The duration ended in December 1945, so I don't know if they could automatically get out, too.

MAJ Gurney: Did this massive and sometimes involuntary demobilization create any bitterness among the nurses? Were you aware of any?

BG Dunlap: Yes, for people who didn't want to get out. There were people who had been in civilian nursing. They came into the military for the war and they liked it and they wanted to stay in but couldn't. It created a great deal of bitterness and questions. People didn't understand what demobilization was. They wanted their loved ones to come home, but why did they have to get out then? It was difficult.

MAJ Gurney: In talking with your peers of that time, did they describe having trouble finding jobs or did they not want to work? It would seem to me very difficult for the civilian community to absorb this number of nurses.

BG Dunlap: I can't think of any who had problems. I'm the only one from my unit who made a career in the Army. Some of them were married and they couldn't stay in and have families so they wanted out anyway. I can't think of any that got out wanting to stay in nursing but couldn't find work.

MAJ Gurney: Those who wanted work seemed to find jobs?

BG Dunlap: Again, I can only speak for my unit, because we kept in touch with each other. Some of them went into the Veterans Administration. I'm thinking particularly of Lucille Bratcher and Thelma Meyers. They were from around Dallas/Fort Worth and they went to work at the VA hospital in the Dallas/Fort Worth area. They wanted to be up there too because with all these veterans who had returned and were hospitalized in the VA hospitals for long-term care, the need was so great.

You know I talked earlier about those "Yankee" nurses. The Yankee nurses all went back home, up North.

For years I've heard former Army Nurses say, "They made me get out." They were bitter about it. Even so, when RANCA meets you can still feel their closeness to the Army Nurse Corps. They want to belong to the Retired Army Nurse Corps Association. They say, "I would have stayed in. I could have retired too if they hadn't kicked me out." That was something that you heard all the time, "I got kicked out." That's a very negative connotation, "kicked out."

MAJ Gurney: That's too bad and it's certainly not due to any fault of their own. The need just disappeared very quickly.

BG Dunlap: I'd like to tie this in with something else. When the Korean situation started and we needed people to come back on duty, some of those who had been forced out said, "Look, I disrupted my career once. I'm back in my career now. I don't want to come back because you might do the same thing to me again."

MAJ Gurney: Yes, it hurt us in the long run.

Brooke Army General Hospital

MAJ Gurney: Going back, now, to your return from World War II. You've recovered from malaria, a leftover from your Southwest Pacific experience. Describe your experiences then after you recovered from that illness.

BG Dunlap: Well, actually I had to recover from that particular bout of malaria, a lingering fever of undetermined origin, and abdominal surgery. This was followed by six months' temporary duty, at which time I was able to return to full duty even though I still had the malaria bug in me. I want to put this in here now, because I got malaria in 1943 and continued to have bouts of malaria, with the chills and fever typical of malaria, until 1950. While I was stationed at Fourth Army headquarters in the Surgeon's Office on recruiting, I would never know when I was going to come down with one of those bouts. I might be out on a recruiting trip and suddenly have one of them. So, finally the surgeon of Fourth Army gave me a new medicine, which we referred to as "white Atabrine." He put me on a six-month course, first at a very high dosage and then gradually reducing it until it was discontinued at the end of the six months. I never had any more malaria after that.

MAJ Gurney: You called it "white Atabrine." Does it have another name or is that really what it was called?

BG Dunlap: I want to think it was a chloroquine, but I'm not sure. But it was for malaria. I was sensitive to quinine so I couldn't take that. It was in 1950 that I finally had my last malaria. I'm sure there were many others who came back with malaria, taking it with them when they went back into civilian life. They probably had the same experiences.

MAJ Gurney: During your limited duty assignment at Brooke, what were your duties?

BG Dunlap: Well, actually I was on full duty except that I had some duty time to complete the medical evaluation of my physical condition to see if I was going to be able to function. Even so, I did my full duty.

MAJ Gurney: On what unit did you work, or in what clinical area?

SURGICAL RESEARCH UNIT

BG Dunlap: At first I was on Ward 9, which was the women's ward. Then I worked on the officers' ward. Then Major Edward Pulaski, he later became Colonel Pulaski, brought the Surgical Research Unit from Halloran General to Brooke. I helped set up the Surgical Research Unit, as it was known then, and worked on that unit. As I look through my 201 [personnel] File, I see that Colonel Pulaski wrote a recommendation for me when I applied for Regular Army.

MAJ Gurney: He was the founder of that unit?

BG Dunlap: He brought the unit down, yes. Their research had been at Halloran General in New York, where they were working primarily with osteomyelitis, the different bone infections. It was the bone infections that necessitated amputations. They were trying to keep from having to do the amputations. That was when he first developed his "Pulaski juice" using the streptomycins and the penicillins intravenously. Don't ask me what the formula was. I could never remember that.

MAJ Gurney: It was a combination of antibiotics?

BG Dunlap: We had streptomycins. It was also at that time he was working on bacitracin, which was an experimental drug. Drs. Melonie and Johnson came down from Chicago and reviewed the group that they had been working with. I remember those studies so vividly because they had kidney complications. We had to do the PSP test using red dye to test renal function.

MAJ Gurney: What was the PSP test? Did you give the patient some substance that they should excrete through their urine?

BG Dunlap: PSP. It's a red dye. They were determining the renal toxicity of bacitracin and they did find that it was toxic. They altered the dosages and tested again. Another drug that we were using was Furacin. Furacin was a yellow paste-like substance, almost like an ointment, and it came in a dark purple jar. I'll never forget that. We treated it like a narcotic or a controlled substance because it was experimental. We took the patients who had the terrible bone sequest into the treatment room. There their wounds were cleaned out. We melted the Furacin and the doctor injected it into the cavity. It solidified into the cavity. Once it solidified it stayed in there like a pack, I guess you'd say. Eventually, it would be absorbed.

MAJ Gurney: Did these treatments, the experimental drugs, and the activities that you were doing on the Surgical Research Unit require any special activities of the nurses? How did they participate in this?

BG Dunlap: Nurses did no formal nursing research, which has been the history of that unit. We provided the nursing care to support the medical research that

was being done. Major Pulaski, and Captain Charlie Mathews, physicians, came down with the unit and Captain Sally McAlister was the chief nurse who came down with the unit. They had all worked together as a team at Halloran General. They really discussed the patients and answered our questions. We were involved and we knew what the plan of care was for the patients, but we did not conduct any nursing research.

MAJ Gurney: Were there any initiatives or movement from the nurses to start their own research?

BG Dunlap: No.

MAJ Gurney: It was just not considered a part of their duties.

BG Dunlap: We were just part of the medical research.

MAJ Gurney: Did the nursing activities with these patients, in support of that research, require anything special of the nurses? Other than regular nursing care, were there any new and different things that you did related just to that?

BG Dunlap: Patience. It required patience and understanding, not p-a-t-i-e-n-t-s, but patience and understanding. We had officer and enlisted together, and these patients had been together for quite a long time. Many of them had been transferred down here from Halloran General. They were a special group and they knew they were special. They did not necessarily want to comply with the hospital rules and regulations. They were a dear bunch and we loved every one of them, but we wanted to spank them sometimes.

The total environment was different than it was on any other ward. Remember this is the time when your team was your ward officer, your charge nurse, and your wardmaster. There was discipline on the other wards. The patients had to help you do the work. Nursing service still served food out of their ward kitchens and the patients helped. They did KP and things like that. But not this bunch, no way were they to do anything like that. This assignment required an appreciation of the importance of that relaxed, informal environment. I was kind of GI, and this was quite different. Having been overseas in wartime, where discipline was strict, I thought I was caring for a bunch of spoiled patients. But after working there a while, I became a part of it.

MAJ Gurney: You relaxed a little bit, too, and you ran by a different set of rules.

BG Dunlap: It was just an entirely different environment.

MAJ Gurney: Is that perhaps because of the special needs of that unit? Perhaps because of the particular degree of grief and suffering they were going through?

BG Dunlap: There were long periods of hospitalization. It brings to mind one patient who was there such a long time. He had one arm and one leg amputated and they were trying to save the others, which they did. But the patient had long, long hospitalizations. Patient outcomes were doubtful, even though survival was up. Many had to wear braces along with using their canes.

They were allowed to keep their civilian clothing on the ward. Well you know that was "verboden" in an Army hospital. Everything had to go to the clothing room. On a regular unit when the patient got a pass, he had to take his pass down to the clothing room to check out his clothes so that he could go out on his pass. Then he turned his clothes in down at the clothing room, got his ward pajamas, and came back to the ward. That was the policy throughout the rest of the hospital, but not on this unit. The patients had lockers and had their civilian clothing with them, so when they wanted to go out they could just go out. Those patients could tell us more about San Antonio than a lot of the people stationed there.

They had a good time. One of the patients, Colonel Reagan, and one of the nurses who had been with him up in Halloran General were married while he was there on the unit. Of course, we all turned out at the Main Post Chapel for the wedding. He had a long leg brace on and I'll never forget how determined he was to walk down that aisle. Such determination, he was going to walk with just a cane, and he did! But it was common to go over to the Tee-Pee, which was a big steak house over there on Austin Highway, and find half of our staff and half of the patients over there having a good time.

MAJ Gurney: Was the unit part of the administrative structure at Brooke? Or was it independent or under Research and Development Command?

BG Dunlap: To my knowledge it wasn't under Research and Development Command. It was assigned to Brooke because it was staffed with nurses and corpsmen from the rest of the hospital. Physicians rotated through there. Colonel Pulaski commanded, or you might say he was in charge of that unit, but I don't know what his title was. We called him the commander of the Surgical Research Unit.

MAJ Gurney: Did it remain focused on the bone recovery, etc., during the time you were there?

BG Dunlap: No, they treated not only bone healing but infection too. I remember getting some of the patients, and this was another instance where bacitracin was used, with hand injuries and infected hands. They'd do an irrigation and debridement [I & D] and put them on quarters for sometimes a couple of weeks until that healed. Then they could go back to do the particular work that they needed. They were infiltrating with the bacitracin instead of doing the I & D, to determine if they could cure it that way, returning them to duty sooner and with less loss of tissue than from the I & D. That was successful. They were concerned about infections and in particular the use of streptomycins.

MAJ Gurney: So the work of the unit was really focused on the revolutionary development of the antibiotics and their new capabilities.

BG Dunlap: It was really an interesting assignment. Just before I left Brooke, they got their first burn patient, and this was revolutionary. If I remember it correctly, I know where he was on the ward. He was out on the porch, which is now called the supply room. He was an Air Force pilot and had been burned in a crash. He wasn't severely burned like you'd think in terms of the burn unit now, but they'd gone in there and started treating him. I left shortly after that because I was transferred to Fort Chaffee, Arkansas. I've often thought over the years that I could not work in the burn unit. I just don't think I would have been able to continue in the Surgical Research Unit as it eventually became the burn unit. It was not my field. It takes a special kind of person to work in the burn unit, very special.

MAJ Gurney: It really does. So, you went to Fort Chaffee. When did you go to Fort Chaffee, about 1949?

BG Dunlap: 1949.

THE ARMY-NAVY NURSE ACT

MAJ Gurney: Okay, then this question I want to ask you precedes that. In '47 Congress passed the Army-Navy Nurse Act giving Army Nurses the opportunity to join the Regular Army. Did you feel the impact of that at all?

BG Dunlap: I felt the impact of that because in 1947, I wasn't sure whether I wanted to make the Army a career or not. I had stayed in. I loved it. I loved what I was doing, but it seemed to me if I said I was going Regular Army that would have been like joining the convent for the rest of my life. I was 25 years old. They said we didn't all have to do it just then. We could have a period of time before we'd have to make up our minds about joining the Regular Army. We'd either go Regular or Reserve. AUS is what we were. So, I wasn't sure what I wanted to do.

In 1948 I had made up my mind that I wanted to join the Regular Army. About that time I was pitching on the Brookette softball team downtown in the city league. The catcher missed the ball—I probably threw it wild—and the runner from third base came running in. I covered home plate and the runner hit me from behind and knocked me over, hitting my right knee. I got up realizing I'd been hurt, but I finished pitching the game, which we lost, and then went on duty. I was on night duty then. During the night I found out I was having trouble hobbling around. I really would become annoyed on this women's ward. A woman at the far end of the hall rang the bell, wanting to know what time it was, and I'd have to hobble all the way down there to tell her what time it was. I'm being facetious now, but really that's how I felt with this bad leg. I'd be sitting there in between bells with a hot water bottle on my leg. We used hot water bottles then. When I went off duty the next morning I went to the orthopedic clinic and they put a long

leg cast on it. So I went through a period of time of hospitalization and convalescent leave in a long leg cast. Finally, I had to have surgery done.

It may be of interest to you, that little scar there. Most medial meniscus surgeries created big incisions but this particular procedure, and the knife that was used, was invented by Colonel Knox Dunlap. He just died this week. He was the assistant chief of Orthopedics at Brooke, and Colonel Milton Thompson was the chief of Orthopedics. Colonel Knox Dunlap did the surgery. It was a Friday in April, the day of the Fiesta parade downtown. I had quite a long period of convalescence here until I could get full motion back and forth. There was a regulation that you could not apply for Regular Army within one year after joint surgery. So, I had to wait from 1948 to 1949 until I could apply for Regular Army.

I wanted to apply for Regular Army and at the same time I had orders to transfer me to Camp Chaffee, Arkansas. So the dear sweet civilian lady working in personnel, whom I got to know quite well, wanted me to go before the Regular Army board here, not to take a chance going before a board of people at Camp Chaffee who didn't know me. So, they convened a Regular Army board here at Brooke General Hospital. Colonel Louis Mantell, urology (he had done a residency here); Major Fran Easley; Major Margaret Harper; and Major Louise Romachek sat on my Regular Army board. Most of them had been my supervisors and I had worked with them, so I thought my Regular Army board was pretty easy. They knew me; they knew my work. They asked me the questions they had to ask me and I then went on to Chaffee to comply with my orders.

I thought that was the end of the world. I had been at Brooke from 1946 until 1949. I had lived in the room at Splinter Village and they counted me with the inventory, I'd been there so long—six sheets, four pillow cases, and Lil! I thought Brooke would fall apart if I left there. It didn't. I was on leave and the orders came through for me to go to Chaffee. It's just like those sneaks to put you on orders to go when you're on leave. But I went on to Camp Chaffee, Arkansas.

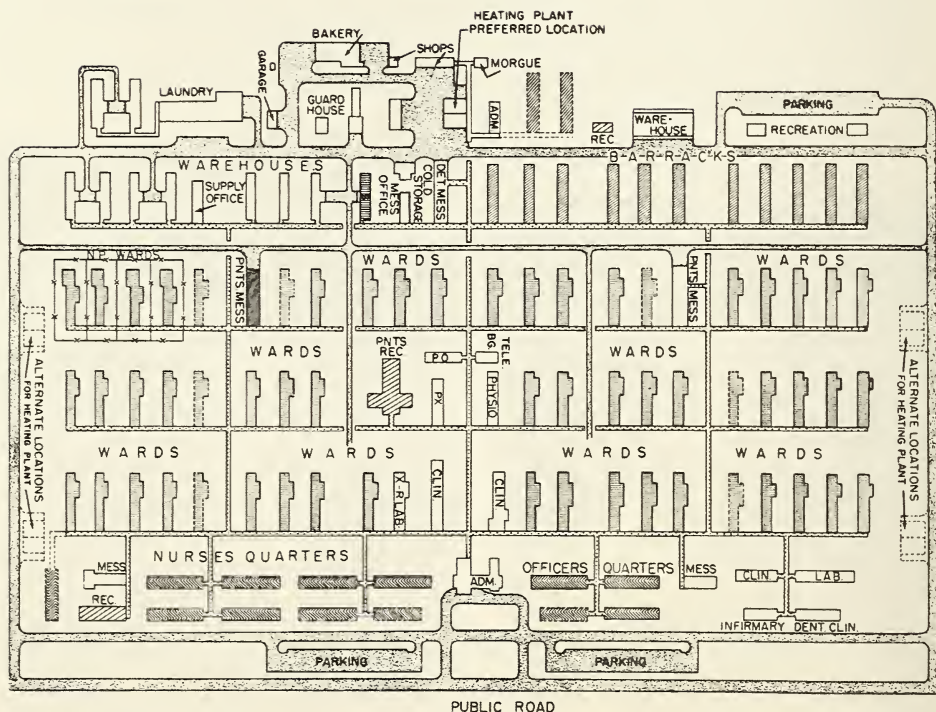


One-year-old Lillian with her mother in San Antonio, 1923 [Family photo]; below left, Lillian Dunlap, graduate of the Santa Rosa Hospital School of Nursing, 1942, at age 20 [Santa Rosa Hospital School of Nursing]; below right, 2d Lt. Lillian Dunlap outside a patient care ward, 59th Station Hospital, Los Negros, Admiralty Islands. [Personal photo]





59th Station
Hospital on jungle
maneuvers—
Lieutenant Dunlap,
left, and 2d Lt.
Mary Katherine
Green outside the
nurses quarters,
Camp Chaffee,
Arkansas, October
1943 [Personal
photo]



A typical plan for a cantonment-type hospital [From Clarence McKittrick Smith, *The Medical Department: Hospitalization and Evacuation, Zone of Interior, United States Army in World War II*, Washington, D.C.: U.S. Army Center of Military History, 1956.]

November 1944–March 1945

ADMIRALTY IS

NEW GUINEA AREA

1943–1945

 Duty Station

0 150
Miles

B I S M A R C K
S E A

Madang

Saidor

Huon
Peninsula

Finschhafen

Cape Gloucester

Arawe

NEW BRITAIN

Lae

Huon Gulf
Salamaua

Wau

S O L O M O N
S E A

NORTHEAST NEW GUINEA
PAPUA

January–November 1944

Gona

Buna

Dobodura

Kokoda

Port
Moresby

Kiriwina I

Goodenough I

December 1943–January 1944

Milne Bay





*Lovie Arnold and Lillian Dunlap
in front of the surgical wards, 59th
Station Hospital, Los Negros,
Admiralty Islands, December 1944
[Personal photo]*



*American troops leave the post chapel following services, Admiralty
Islands, January 1945. [Personal photo]*



Lieutenant Dunlap aboard the Marine Jumper during the trip home from the Philippines, November 1945; below, left to right, 1st Lts. Leona J. McHugh, Lillian Dunlap, and Ruth Crowell aboard the Marine Jumper en route from Manila to California, November 1945.
[Personal photos]





*Officers assemble for Army muster, Brooke General Hospital, June 1946;
below, the first treatment room in the new Surgical Research Unit,
Brooke General Hospital, 1947. Capt. Sally McAllister stands in the
background at left. [U.S. Army photos]*





"The Brookettes," Brooke General Hospital softball team, 1947. Lillian Dunlap is standing, far left. [U.S. Army photo]

The Developmental Years

Camp Chaffee, Arkansas

Major Dorothy Ainsworth was the chief nurse. I think of her as the first person to have a strong impact on my future and my career during the postwar time. I went to work on the surgical ward at Camp Chaffee. [Captain] Jeanne Treacy was charge nurse of a surgical ward that also had the recovery area. She was our first Army Nurse to go to the short Command and General Staff course and later became chief of the Army Nurse Corps Assignment Branch at the Office of The Surgeon General on two occasions. But let me follow through with the Regular Army before I get into the other.

Major Ainsworth, who later became Lieutenant Colonel Ainsworth, called me into her office and said some orders had come dated 13 September 1949. They were my appointment in the Regular Army. I was to be appointed a second lieutenant. I had seven years' service at that time. Those who were integrating into the Regular Army in 1947 were given constructive credit back to the date when they had come in the service. Therefore some of them came in as first lieutenants, not second lieutenants, and their date of rank went back to their entry date. After applying that policy in '47 and '48 they discontinued it in '49. So I debated. Do I want to go into the Regular Army as a second lieutenant with my date of rank at '49? I already have almost seven years of service! But I had to make a decision. I talked to Major Ainsworth, our adjutant, and everybody else. I didn't want to be a second lieutenant in the Regular Army. All my peers were first lieutenants when they came in. Why couldn't I be? Well, the regulation had changed. I accepted it and became a second lieutenant, Regular Army, 13 September 1949. I remember that because it was going to have an impact on the end of my career. So I joined the Regular Army, but since I was serving as a captain I stayed on as a captain. It didn't make any difference in the rank I wore.

I worked down on the surgical ward. It was a cantonment hospital with those long ramps, and we each took our turn at supervision, night duty supervision, and everything else. [Captain] Irene Williams was Major Ainsworth's assistant chief nurse. She also served as the supervisor of the outpatient clinic. She still lives here in town. She was an older nurse and about to go on a month's leave. Major Ainsworth came to me and asked me if I would like to come into her office and work in the assistant's role there while she was on her vacation. I was flattered, and scared, for sure. But I went ahead and worked in her office and was the assistant chief nurse during that time. When Irene came back from her thirty days' leave, Major Ainsworth decided that she wanted to keep me as assistant chief nurse, so you see what I mean about my career. She kept me in as the assistant chief nurse,

and Irene Williams went on down to the outpatient clinic as the supervisor. She divided the two jobs. Instead of Irene holding both jobs, she gave Irene the outpatient clinic and me, assistant chief nurse.

MAJ Gurney: Was Irene Williams also a captain?

BG Dunlap: Yes, but senior to me.

MAJ Gurney: How were nurses rated at this time? Were they rated? What kind of a rating system was there?

BG Dunlap: The chief nurse rated the assistant chief nurse.

MAJ Gurney: It was simply one person writing an efficiency?

BG Dunlap: As far as I know, because I never wrote an efficiency.

MAJ Gurney: So, there was no rating conflict caused by Captain Williams being in the outpatient clinic and senior to you and you being the assistant chief nurse.

BG Dunlap: I didn't compare notes with Irene. Major Ainsworth probably did the efficiencies on all of her captains. As far as I know, I never wrote an efficiency.

Once again I had quite a learning experience. Irene didn't talk to me. She was hurt and I could appreciate that, but that makes a very awkward, unpleasant situation when you're living in nurses' quarters, eating in the same mess hall, and going to the same officers' club. By the way, Jeanne Treacy was the club officer also. She did a tremendous job as club officer. We took one of the old wards and made it into an officers' club. We had such a good officers' club at the hospital that the people from the rest of the post wanted to come to our club for their parties.

Word came through that they were going to close Camp Chaffee, and they started phasing out the staff. Major Ainsworth was to leave Chaffee and go to Fort Benning, Georgia. I was to be left to get my first experience as chief nurse. Major Ainsworth assured Lieutenant Colonel Augusta Short, chief nurse at Fourth Army Area, that I could handle it as chief nurse at Chaffee.

As we began to close Camp Chaffee, they reassigned the nurses and doctors to other places and closed down the wards. We were gradually closing it down, and finally there were six nurses left at Chaffee. This was quite an experience because as they were cutting down on the number of nurses, they also cut down on the number of patients. Our commanding officer, Colonel George Peers, was a surgeon. Captain Keifer was a surgeon. They kept Major Gross on as the chief of Medicine.

SICK CALL AT CAMP CHAFFEE

We still had troop dispensaries to cover and we didn't have physicians to cover them. I covered the troop dispensaries. As chief nurse, a staff car picked me up in the

morning and took me out to the troop dispensaries. Captain Cooper covered some of them, but I covered a large number. I went out and held sick call at the troop dispensary, and any of the troops who I felt should be seen by a physician I sent up to the hospital where they were seen. They didn't have physicians to run the hospitals and run troop dispensaries too. When I finished holding sick call in the dispensaries, then I went back up to the hospital where I made rounds to the wards we had open.

MAJ Gurney: Let's talk more about your experiences holding sick call at Camp Chaffee. You said that you were really working in an expanded role there. How did you handle the patients? Did you have a certain protocol for medications that you could give them, like for cold medications or something else?

BG Dunlap: We had what we had in all the wards and in the troop clinics. Certain medications we could give, for instance if they had athlete's foot or if they had URI [upper respiratory infection] symptoms and were not running a fever. Of course, I listened to their chest. I knew that if a patient was running a temperature and I heard congestion, there was nothing that I was going to do for that patient. I'd send them right on up to let them be seen by the physician. Now, if they weren't running a temperature and their chest sounded clear but they had some of the URI symptoms, then I had medications that I could give. These were the things that the doctors went by when they were out in the clinics.

MAJ Gurney: So, you followed certain protocols for a few minor illnesses. Was it the overall effect of the drawdown in the medical clinics that there were also fewer people coming into sick call?

BG Dunlap: This is what they kept saying—that fewer of them were coming in. But I was still kept busy.

MAJ Gurney: They knew they couldn't get away with malingering though.

BG Dunlap: Apparently, they knew that I would identify the ones who I questioned in my mind. I knew they had to be seen by someone other than me so I'd send them up to see the doctor and then the doctor would make the decision whether they'd be admitted to the hospital or sent back to duty. Most of them were admitted to the hospital.

MAJ Gurney: That experience really did probably have an impact later on in your career. At that later stage in your career you threw your support to the Contemporary Nursing Practice Program, the Nurse Clinician Program. That may well have been one of the reasons why the Army Nurse Corps gave early support toward advanced nursing practice.

BG Dunlap: I think it helped that I knew it could be done. I knew there had to be parameters of practice, and once those were established we could function. This

led to the controversy related to physician assistants. Do you want me to go into that now because I can go into that in detail?

MAJ Gurney: We've discussed that and it will be included in a later section related to advanced nursing practice.

OTHER CHIEF NURSE DUTIES

BG Dunlap: As chief nurse I was assigned all of the furniture and linen and everything in the nurses' quarters. The nurses were assigned the property on the wards. They used to kid me. The nurses said I'd come over and I'd pull them out of bed every morning to count the linen, to be sure I wasn't going to lose any. I didn't do that, but they used to kid me about it all the time.

After I made my rounds, I went to the office to take care of any correspondence and other paperwork. Then in the afternoon I held outpatient clinic with the physician. When I finished in the outpatient clinic, I made rounds down the ramps through the wards for the afternoon and returned to my office to finish up anything that had to be done at the time. Then I went off duty.

Later, as we got down still more, we had an operating room nurse for a time but did not have a nurse anesthetist. Finally the operating room nurse left and we were only doing emergency surgery. To do that, I took call in the operating room even though I'm not an OR nurse. If the patient could have a spinal, the physician gave the spinal and I sat with the patient, then, at the head of the table. The commander and the captain scrubbed up and did the surgery. If the patient had to have general anesthesia, the young captain gave the general anesthesia and I scrubbed and assisted the commander with the surgery.

These were some of our experiences. I guess I was just so naive at the time. All my career I was given jobs and I never thought, well I can't do that. I thought, well, that's my job. I'll do it.

MAJ Gurney: It was a tremendous job to do all of that, covering all of those areas. Did you have any civilian nurses working in the hospital during that time?

BG Dunlap: Not at that time. Not as we were closing down. To complicate this, they were going to keep the main post open, with skeleton housekeeping details, to maintain the post. One of our assignments was to leave a troop dispensary staffed so that they had one dental chair in it to take care of any dental emergency they might encounter. We also needed to leave them a limited pharmacy. So that was my responsibility. I had to work with the chief of Supply to see to it the pharmacy was set up. Then I turned in equipment as we closed wards, and closed down the nurses' quarters. I'll tell you a little story about the nurses' quarters.

CLOSING THE NURSES' QUARTERS

At Camp Chaffee Major Ainsworth had been able to give our nurses' quarters the most beautiful blond metal furniture, instead of that old beat-up wooden stuff

that the Army had. All of it was so pretty and we were very proud of it. As we began to close down the hospital and the nurses' quarters, I got wind that they wanted to keep that pretty furniture and move it down for the people who'd be living on the post keeping the post open after they'd closed the hospital. That would move the nurses' quarters furniture to family quarters. I got in touch with Colonel Short, chief nurse at Fourth Army. With her help, we set up a system that when I was ready to turn in that furniture, Major Peg Harper, who was chief nurse at Fort Sill, put in her requisition for that furniture. I sent a copy of a lateral transfer down to Colonel Short to show what I was doing. Later on in '51 or something like that, when they opened Fort Polk, Sill had that pretty blond furniture and Fort Polk got Sill's old furniture.

MAJ Gurney: During that period, 1947 to 1949, what particular changes were going on in the Army Nurse Corps? What changes were you aware of that may have evolved as a result of this wartime experience?

BG Dunlap: Not many really. The way personnel was handled then, the chief nurse of an Army Area had greater authority within her Army Area. If she had a shortage of nurses down at Fort Polk, she could call up to the chief of the Army Nurse Corps Assignment Branch, who was Lieutenant Colonel [Agnes] Maley at that time, and say, "I'd like to send some of my nurses from Fort Sill to Fort Polk." Or Colonel Maley could call down and say, "We need X number more nurses" at a station, and the chief nurse of the Army Area could identify the ones within their area to send to that station. That's what they did when they opened Fort Polk. So the chief nurse of the Army Area really had more authority. We don't even have chief nurses in Army Areas now [1987]. But when I was chief nurse of an Army Area—I had First Army—we didn't have that type of authority. The orders came. Of course, they'd ask us for recommendations, but the orders came from The Surgeon General's Office. We didn't really have any authority to move them around on TDY and whatnot within our Army Area.

MAJ Gurney: But in 1947 and 1949 they did.

CLOSING THE HOSPITAL

BG Dunlap: In 1949, when I was there at Camp Chaffee, they did. I'm trying to think about nursing policies. I can't think of anything that stood out. Camp Chaffee was to close, and on the 3rd of January 1950, we closed the doors and I left. I stopped at a Texaco station at Fort Smith and the man there said; "You'll be back. You'll be open again." The Secretary in the Army at that time was Frank Pace who was from Arkansas. So, we closed it on the 3rd of January 1950 and it reopened in August 1950. It's interesting, as we were closing the hospital, a contract had already been let and they were starting to resurface the floors with some kind of funny composition. It was kind of a pinkish color. They were preparing to refinish all those floors and repaint it inside and out. It used to just upset me so to

think of all that money going to fix that hospital like that while we were preparing to close it. But thank goodness they did it, because when the Army reopened it, it was in good condition. I didn't reopen it but I was at Fourth Army at the time of its reopening in August. They could just move in.

There's something else related to closing a hospital. I guess I have a good deal of Scotch blood in me. I don't like to throw anything away. As we were closing the hospital, we couldn't return any supplies that had been opened. We had big jars with a thousand tablets of aspirin; remember, we had jars of medicines in the cabinets on the wards. We'd take tablets out of the thousand jar and put them in the smaller jars in our cabinets. Once we'd opened a thousand-tablet bottle, we couldn't return that to Supply. All of the rubber goods and other things like that, Supply wouldn't take them back. Our supply officer worked very closely with the Veterans Administration hospital. I think there was a VA hospital over in Manville. He worked very closely with the VA hospital and also the civilian hospitals so those things weren't just thrown away.

Fort Hood, Texas

Okay, so when we got ready to close Camp Chaffee, Colonel Maley was chief of assignments in Washington. She worked with Colonel Short, who was the chief nurse at Fourth Army, to reassign the nurses. They asked the nurses where they'd like to be reassigned, and they truly tried to reassign them where they'd like to go. But they didn't all get to be reassigned where they wanted. I got orders to go to Fort Hood. So, I closed Camp Chaffee and I came home on leave. I went in to see Colonel Short to report to her how I had left everything. It was kind of to give her an after action report, I guess. At that time, I didn't know those fancy words. After my leave, I reported to Fort Hood and was assigned to work on the surgical service. Fort Hood was also a cantonment hospital at that time. Major Gay Falcone was the chief nurse there. Gay was barely five feet tall. She had one of those conditions where her mandible slipped, so when I reported in, they said, "She's down in the mess hall." I went down to the mess hall and here sat this tiny little thing with a green scrub cap on and the bandage underneath holding it on. "That's my chief nurse," I thought. She was a tremendous chief nurse. She was only there a while and then she was transferred someplace else. Lieutenant Colonel Elizabeth Hannah came in as the chief nurse.

I went on duty there at Fort Hood. I was there three months when Major Falcone came in to me one day and said that she had a phone call from Colonel Short at Fourth Army. She wanted me to come to Fourth Army on TDY to do some recruiting. Well, I had no idea what this was all about, but I reported to her on TDY. This was in 1950.

MAJ Gurney: Is it winter of 1950? Or are we getting toward June of 1950?

BG Dunlap: 3 January. I was there three months.

MAJ Gurney: Okay, I'm just trying to put it in relationship with the 25th of June [the date of the North Korean incursion into South Korea].

Fourth Army

BG Dunlap: Well, I'm going to come to that. What she had done was gotten permission to bring me into the Surgeon's Office to set up a recruiting program primarily for the reserve units. We had a lot of reserve units in the Fourth Army Area and didn't have many nurses in them. I had never done any speaking. Major Ainsworth sent me to Oklahoma City to recruit one time. But otherwise, I had always been in the hospital in the clinical area. Colonel Short explained to me that she wanted me to develop a program to recruit nurses in the Fourth Army Area, which was Texas, Oklahoma, Arkansas, New Mexico, and Louisiana—the five-state area. This was quite an experience. Colonel Short is the second person who I had worked with, who had a tremendous impact on the career that Major Ainsworth started for me. I had to come up with a plan for the Tenth Annual State Nursing Convention. Also, I would work on conventions in the five-state area, would speak in the schools of nursing throughout the five-state area, and would try to compose publicity releases. The recruiting period is quite a story in itself. I learned so much while working with Colonel Short. I learned from her as a person. You've met her.

MAJ Gurney: Yes, I have.

BG Dunlap: Oh, yes. You met her yesterday. I learned from her. She's the most humble person. When things came into the office that pertained to her role as chief nurse of Fourth Army, she always showed them to me and discussed them with me. We'd talk about why she did certain things, the reason for a certain decision. It was such a learning experience. So much so that I want to talk about the recruiting part as a separate section. I was there for four months' TDY to set up this recruiting program.

Then I went back up to Hood. I was only back at Fort Hood a couple of months, then I PCS'd [permanent change of station] back down to Fourth Army headquarters. That was it. I was three and a half years there with Colonel Short at Fourth Army headquarters. During those three and a half years, she really prepared me to be a staff officer. Things came in—action papers—and I saw how she functioned on the staff, her decision making. When she was out of the office making staff visits, papers still came in and she trusted me to make the decisions. The surgeon also trusted me to make decisions. He expected me to. If I had any question, I could call her wherever she might be to discuss it with her. And I did, but not often. I guess I had the self-confidence that I could do it because of the way she really worked me into her decision-making process.

I'll give you an example. When they were going to call up the reserves, I remember the American Nurses' Association was going to help us recruit for the Army. They set quotas for the different Army Areas. The Fourth Army had a

quota of 150. Then it was up to Colonel Short to determine where the 150 would come from and to recommend to the reserves and the surgeon which state they should come from. We went over to the reserves and looked in their files—they were such a mess—so incomplete regarding where the nurses were. Who knew where the nurses were? Or were they married? Some of them had children. They didn't even show that they were married and had children. Or where they were serving. One time, Colonel Short was on a trip and the surgeon got a task that required him to produce, within the next day, a document that listed where these nurses were to come from. For instance, x number were to come out of New Mexico, so many out of Texas, etc. He brought it back to me for action. I did it. I gave it to his staff. That established the quotas. When Colonel Short came back, she looked at what I had done. She supported my decisions. Now, she may not have done it that way if she were to do it herself. She couldn't understand how I could do what I did. I don't either. But that was a learning experience because she discussed what I had done—the decisions I had made. Instead of saying, "Hey, you were way off base. This is the way you should've done it," the way some people would, she supported me and pointed out any differences that we might have had.

MAJ Gurney: How do you think Colonel Short came by this capability? Where did she learn to do this?

COLONEL AUGUSTA SHORT

BG Dunlap: Well, it's interesting because Colonel Short is from Mississippi. She had a degree, went to Washington, and was working at the Veterans Administration. Then she went into the Army School of Nursing at Walter Reed. By the time she finished there, she already was a little more mature when she went into nursing. She went into the Army's anesthesia program at Walter Reed. She was a nurse anesthetist at the beginning of her career. From there, she went to her first chief nurse assignment at Fort Thomas, Kentucky, in 1941. Following that, she was sent to Panama to be chief nurse at the 218th Hospital and then of the Panama Zone Command.

She must have had role models along the way. She had so much common sense. She was down to earth, calm, inclined to get it done. That's just her whole approach to things. Learn. What is it we say on the efficiencies? Courage of her convictions? I mean, she wouldn't go along if she didn't agree with things being staffed. She didn't hesitate to put her chop on it to reflect what she believed. But then, when the surgeon made a decision that this is to be done, if it was not exactly what she had recommended she certainly supported the surgeon and was loyal in the implementation of any decision there. But she was a very wise woman—so wise. I was privileged to let my wings flap a little bit under her because I was with her three and a half years. We had fun doing it. It was enjoyable. There were rough times, yes.

MAJ Gurney: Was this some of the first experience with nurses devoted to recruiting reserves? We weren't doing that across the board at that time, were we?

RECRUITING

BG Dunlap: No. They had brought some nurses in like [Major] Inez MacDonald Moore. She had come in to Colonel Short's office for a period of time and had done some recruiting. But they were never assigned to recruiting before. They brought [Lieutenant Colonel] Nancy Macum and [Lieutenant Colonel] Thelma Munn into The Surgeon General's Office to start setting up some recruiting programs. I was assigned in the Surgeon's Office. There was always a debate about where they would assign the nurses to do recruiting. Should it be in the Surgeon's Office? Or in the Recruiting Command? Back at the headquarters? Army Area headquarters? In Third Army [Captain] Helen Dunn was assigned to recruiting. [Lieutenant Colonel] Ruby Bryant was chief nurse of Sixth Army and [Captain] Pat Johnson and [Captain] Bertie Chrisman were assigned in Sixth Army. I think they were assigned to the Surgeon's Office.

MAJ Gurney: So, it wasn't uniform in terms of how they were implementing it?

BG Dunlap: Either they were assigned to the Surgeon's Office or they were assigned to Recruiting. They didn't have a Recruiting Command per se at that time. Recruiting at that time was a multi-branch organization. It wasn't just an office for recruiting nurses. They were in a general recruiting office.

MAJ Gurney: What were the reasons for one approach versus another?

BG Dunlap: Colonel Short brought them into the Surgeon's Office first. Personally, I liked that approach because we had the professional identity. As I made rounds to the recruiting stations throughout my area, the picture that was painted of stations at that time was of busy recruiting stations that were often in the basement of the federal building. The recruiting sergeant would sit there with his feet on the desk, perhaps smoking or chewing tobacco. He was a "good ol' boy." There were some good ones. But often they were not very professional. But this stereotypical recruiter knew all of the people in town. Remember, this is down in this part of the country, the Southwest. It may be different someplace else. But he knew the power bases in his towns. He met his recruiting quotas. And he got to homestead in that job.

That is not the environment that I wanted to be associated with. I went to all the different schools of nursing to speak. I wanted to keep my relationships with them professional. The nurses were coming into the Army Nurse Corps as professionals. I used to hate to send them down to the recruiting station to get help filling out their forms or make arrangements for their physicals. They weren't always the brightest people in those recruiting stations. (Laughter)

It's the truth. It was so disturbing to see.

There were drawbacks to being assigned outside the regular recruiting organization. We didn't have brochures. We didn't have training aids. In recruiting they had funds for that type of thing. We didn't have the budget for that. They began to put out brochures from The Surgeon General's Office. We'd get some of the books and things like that to take to the conventions. We didn't have money for

displays. We'd get a table to put out our brochures, and that was it. Well here we were, competing with Herman Hospital and Baylor Hospital and groups like that to recruit for nurses. Well, we certainly wanted something more attractive. So I made my own displays. I've got a picture someplace. I may have shown it to you, the birdcage. Did I tell you about the birdcage display?

MAJ Gurney: I don't think so.

BG Dunlap: I wanted a display that I could take to set up on a table at a convention. So my daddy built me a box with two cutouts for 8 by 10 color transparencies on each of the four sides. He took Mama's birdcage stand and cut it off and hooked the box over the top of the birdcage stand. He put a light bulb in there so we could turn on that light bulb and then we could see the color transparencies and turn the box around. And there went Mama's birdcage stand, cut down to this size, about a foot and a half tall. (Laughter)

I made my own posters. I did find an artist at a recruiting station who did some silkscreen posters for me. One year when I made rounds, I saved all of my Christmas cards and Colonel Short's from around the world. I made a big poster from those Christmas cards. I took green and red shiny paper and cut out a shape like the map of Korea and put the Christmas cards from Korea on it. Or I cut out the shape of the map of Germany and put Christmas cards from Germany on that. I went into the schools to talk about the places where nurses could be assigned. It was a disadvantage to not have a budget for training aids. If I had been in recruiting I probably would have gotten some of those things. But, for the time I was on recruiting, I felt that it was more important that I had the advantage of the professional relationship. Everybody knew Colonel Short. The directors of the schools of nursing throughout the area knew Colonel Short. She was active in the state nurses associations and all the conventions. That was a relationship that I wanted to establish so that the directors of nursing would tell their senior students to get in touch with me to let me come talk with them.

I'll give you an example. Ira P. Gunn was a student at Lilly Jolly School of Nursing in Houston. This was the Baptist hospital there. I recruited her. When she was going to receive her appointment, I put on my dress white uniform and I flew down in a little plane to Houston to give her the appointment. That was the type of relationship that I felt would bring in more nurses than if the nurse recruiter had gone into the recruiting stations.

MAJ Gurney: Tell me more about the challenges you faced as a nursing recruiter.

BG Dunlap: I carried all of those five states by myself. They may have enlisted recruiters who concentrated on smaller geographic areas. How many do they have on recruiting now?

MAJ Gurney: I don't know. The nurse counselors do commonly cover a number of states. But there is a larger network of nurse counselors and brigade nurses.

BG Dunlap: I had all of Fourth Army. Helen Dunn had Third Army. [Major] Nellie Newell was up in First Army at Fort Campbell I think. Bertie Chrisman had Sixth Army. [Captain] Zita Ireno was in the Chicago area. They had two out in Sixth Army because they had more schools of nursing.

We had six armies at that time. First Army was New England including the Bronx and New York. Second Army was in the Fort Meade area. Third Army was at Fort McPherson, Georgia. We in San Antonio were in Fourth Army. Fifth was just the reverse of what it is now. We used to be Fourth Army and the Chicago area was Fifth Army. When they combined them, they did away with Fourth and made us Fifth. And now, they've changed back. Fourth Army is going up there. Sixth Army was the West Coast.

At Fourth Army we started an Armed Services Unified Recruiting Team. The name was something close to that. In Texas, Dallas had Navy Recruiting Headquarters. They had a WAVE and a Navy Nurse assigned up there for recruiting for their district. Colonel Short then brought in an AMSC [Army Medical Specialist Corps] to her office to do AMSC recruiting. That was Major Martha Moseman. Martha Moseman and I were there at Fourth Army headquarters. They also had a WAC staff adviser, Major Dorothy Zeff. We got Air Force Nurse [First Lieutenant], Helen Mannion, and an Air Force Dietician, First Lieutenant Jean Smith, from Wilford Hall. I don't know if they called it Wilford Hall then. It may have been called Lackland. They were on duty out there and they joined us. A Marine officer, Lieutenant Claire Hall, also joined us.

The Business and Professional Women's Clubs of Texas sponsored our visits to different cities throughout the state. They set up a few days at Lubbock, where Texas Tech University is. I have a book with pictures of our visit out there. They handled all the publicity and all the appointments. We went out to the college and met the president of the college and the different deans. We also spoke to a number of groups. We didn't have a nursing program at Texas Tech. But we were also on TV, radio, the Rotary Club, and the Business and Professional Women's Club. Because they sponsored our visit, it took some sting away from it being direct recruiting. We were sponsored by a respected women's organization in the city. Because of that we were able to get into certain areas that we would not have been able to access if we had individually asked to come in and talk about Navy nursing, or Army nursing, or Air Force nursing. The three of us in nursing always presented our program together when we went to the nursing schools. We could say, "Well, the Air Force has flight nurses. The Navy has ship duty. And what does the Army have?" I'd say, "Well, we have real nursing. We're in the field where the battle's going on, combat nursing." This is what I said. We traveled all over Texas.

MAJ Gurney: What were the differences between the services at that time?

BG Dunlap: Part of it was in their assignment potential. The Air Force had small hospitals as they have today. They had Wilford Hall. But that was their only big hospital. At that time Wilford Hall wasn't as big as it is now. So the Air Force had assignments in smaller hospitals. Although they played up flight nursing, it was

pointed out that not everybody became a flight nurse. They only had a certain percentage of nurses who could go into flight nursing.

The Navy's assignments were along the Coast mostly, and, of course, the Great Lakes. They didn't have the overseas duty that the other services had. None of them had the overseas opportunities that we had. At that time, I think the Navy only had one hospital ship still commissioned. I'm not sure if it was even commissioned or if it had been retired by then. So even serving on a hospital ship was limited. Although recruiters and recruiting posters stressed serving on hospital ships or being flight nurses, those opportunities weren't really there.

The educational opportunities in the Army were much better. It was during this period of time—the '50s—that the Army, under Colonel [Mary G.] Phillips, tried to get our courses established. Colonel Phillips was so education-minded. Colonel [Ruby F.] Bryant also moved to get our courses established. They also worked to get us into civilian schools to complete our undergraduate degrees. The Air Force and the Navy didn't have the education orientation to the extent that we did. Even though Army nursing may not have been as glamorous in the eyes of some, we could point out these things. We presented it in as objective a manner as we could. The three of us didn't get into a debate about which was the better service.

That was the effectiveness and the charm of this concept. As a whole team, we got the women from the different services and the professional community talking together about going on for a college education and a career. It created a really positive image for women in any community we went to. The Oklahoma Business & Professional Women sponsored us in Oklahoma City and a few cities. But it wasn't statewide like it was in Texas. I considered this the beginning of a unified recruiting system for a period of time. A lot of it depended on how much time a school could give to someone to come in and talk about careers. In the curriculum today I don't think they have much time for that. I think some of the recruiters sit in the lobbies of the schools at their little tables.

We were also able to get into the high schools. It was during this time that I helped organize the future nurses' clubs in Texas. The first one was in Port Arthur, Texas, at Jefferson High School. I flew down there to help organize that. As I went around on my own recruiting schedule, I'd meet with students in the high schools to talk about careers and careers in nursing and future nurses' clubs.

MAJ Gurney: Was the unified recruiting unique to this region? Or was it national?

BG Dunlap: No. We started it.

MAJ Gurney: Did it become a national initiative?

BG Dunlap: Well, they've picked up, not in the same form as we had it. But if you look in the history of recruiting, you'll see that they moved to a kind of joint initiative. The DACOWITS [Defense Advisory Committee on Women in the Services] Committee had its first meeting in 1951 in Washington. They invited Lieutenant Commander Elizabeth Leighton, the WAVE officer, and myself to

come to the first DACOWITS Committee meeting. We presented what we were doing in recruiting down here. One of their concerns was recruiting for the military. I can't remember how long we did this unified recruiting, but it was over a year. We'd each go our own ways and then come into the city and work together for the period of time we were scheduled there. It was quite an experience. It was a very fruitful experience, too.

MAJ Gurney: Did you have any measures of its effectiveness? Any way of determining what the impact was?

BG Dunlap: Such as numbers? Who actually came into the service? No. There was no way that we could evaluate that. One of the things that we could evaluate was our acceptance into a community when we later wanted to return to a community to speak. Then I knew the people in the community. I knew the people at the TV station and the radio station. I used the radio most often. I could contact them and I would be able to get in. So that was a big impact. But I don't know what the numbers were. During this period of time we in nursing had a quota. Each Army Area had a quota. It's similar to what they have in Recruiting Command. We were trying to meet our quota. Although we had fewer nurses in Fourth Army and Third Army—Helen and I were constantly first and second in the percentage of our quota that we met in comparison to the remaining Army Areas. It must have had some impact as far as numbers were concerned. We didn't have that many people down here. It's not as densely populated. We didn't have that many nursing schools. All we had were in San Antonio, Austin, Temple, Waco, Dallas, Fort Worth, El Paso, Galveston, Houston, and Beaumont. That was all. In New Mexico there were two. There was one in Santa Fe and one in Albuquerque. Ultimately the one in Santa Fe closed and we just had the one in Albuquerque. In Arkansas we had one at Fort Smith, Hot Springs, Little Rock, and Eldorado. In Oklahoma we had one at Norman, Enid, Onka City, Stillwater, Oklahoma City, Tulsa, and Muskogee. In Louisiana there was Monroe, Shreveport, Baton Rouge, New Orleans, and Lake Charles.

ARMY AREA ORGANIZATION

MAJ Gurney: Tell me about the Army Area organization.

BG Dunlap: We had a chief nurse in each Surgeon's Office and she was the chief nurse of that Army Area.

MAJ Gurney: Was the chief nurse administratively in the chain of command for the Area Army Nurses? Did the chief nurses of the Army hospitals in that Army Area carry the same type of relationship to her as, perhaps, the chief nurses now have with the chief nurse of Health Services Command?

BG Dunlap: It was a similar relationship because the chief nurse of the Army Area was responsible for the quality of care, for the staffing, and, like I said, she

could move people from one station to another to meet a certain need. Of course, she did this with the blessing of Washington. But the chief nurses of the hospitals reported to the chief nurse of the Army Area. When I was chief nurse of First Army in 1968, orders came out of Washington, but they still reported to us. I was in the Surgeon's Office and I was responsible to the surgeon for nursing service in that area. As a matter of fact, Colonel [Charles C.] Pixley was the First Army Surgeon. He used to come down to the office and talk to me. He'd say, "Lil, something's going on in such and such a station. See if you can't find out for me." Because he was married to an Army Nurse, he respected the nurses and the role of the nurses in First Army.

During this time at Fourth Army I experienced a number of other highlights in my life and my career. This was the first time I lived off post. Prior to this time we always lived in nurses' quarters. When I was assigned to Fourth Army headquarters, there were no quarters for the women. There were only four of us, five eventually. We had a WAC staff adviser, and then Major Doris Keaner was the finance officer. Colonel Short was the chief nurse, and I was the recruiter. I lived at home with my parents since this was San Antonio and San Antonio was my home. It was good that I lived at home because I was traveling so much I wasn't home. When I came in, the facilities were there to get the clothes cleaned and repacked so I could take off again. I had a wonderful family who kept the house running. All I had to do was just come in. The meals were prepared and it helped tremendously as you well know, in your current assignment and traveling like you do. It can be difficult.

It was at this time that I met, for the first time, a Chief of the Army Nurse Corps. This was Colonel Mary Phillips. I'll never forget that experience. Colonel Short was having a conference of reserve nurses primarily from Fourth Army Area. She had Colonel Phillips down to speak at the conference. Since I was in Colonel Short's office, I acted as Colonel Phillips' aide. She'd never considered it as such. Colonel Short didn't either. But it was my privilege to take care of some of the logistical support and to spend time with them and to really get to know what a wonderful lady and officer she was. I use that word "lady" because she was a lady, and a fine officer. She was so concerned about the reserves: about recruiting for the reserves, about the quality of individuals going into the reserves, and about the training of the reserves. Consider, now, this is back in the fifties, between '50 and '53.

I also remember that is when we wore that old Hattie Carnegie uniform. Colonel Phillips' official portrait is in that Hattie Carnegie uniform. We all hated it so. Another thing about Colonel Phillips, she was a very devout, religious person. As she later traveled through the Fourth Army Area with Colonel Short, visiting the stations, she'd attend mass every morning. This had to be part of the itinerary to find out when the first mass was and work it into her schedule. She always attended mass before she began her daily activities.

This deep religious being was certainly reflected in her total administration. It showed in the way she dealt with people. She was so kind, so smart, so efficient, but so very kind. She thought of individuals as individuals. She was certainly a role

model. I had unique exposure to several role models during this time. I was able to meet some of the women who became the future leaders of our Corps. I know this influenced my future career. I met Colonel Maley, who was in Personnel. I met Inez Haynes. These people held positions in Washington. When I traveled to Washington to attend some of the recruiting conferences, they were there. I met them in The Surgeon General's Office. You know, that "holy" place you go to. (Laughter)

As a young captain, I got to go there and meet those people. I got to meet Colonel Bryant, who then later became Chief. I got to know them and they got to know me a little more personally than if I were a member of a large nursing staff that they met when they visited a hospital. That certainly had an impact. Those in decision-making positions remembered me.

Just as an aside, when we were at Fourth Army headquarters, an order came out that all of the officers assigned to Fourth Army headquarters had to pass a map-reading test. They found that officers assigned in staff positions sometimes forgot what they knew about map reading. The male officers naturally had gone through their military training, but they weren't very good at map reading. But the females had never had map reading. I had never had any training in map reading. Colonel Short had never had any map reading except Texaco maps! (Laughter)

We knew all of those Texaco maps for Fourth Army. We had to take the map-reading test, which, of course, we did not pass. If you did not pass the test then you had to take the course. They had the course right there at Fourth Army headquarters a certain number of days a week. But, since I was on recruiting, I couldn't take it in residence. I took it by extension. So, as I was traveling around the country, particularly if I flew, I'd be thinking now that green strip must mean a river's running through there. So, I studied my map reading while I traveled. Eventually I took the test and passed it. But that was a rude awakening for a young captain nurse in a staff position.

MAJ Gurney: You said you had a finance officer in Fourth Army. Was this a WAC officer?

BG Dunlap: Yes.

MAJ Gurney: What was the relationship between nurses and WAC officers around this period of time?

BG Dunlap: It was a very close relationship. It was survival. We were at a large headquarters and our work didn't overlap when we were there. But when we traveled or went to some of the social functions, it was a very close relationship. We were the only women. Or there may be only one or two women on a staff. We supported each other.

MAJ Gurney: Did you perceive at all that there might have been either potential for, or friction between, those two groups in other situations? Or in other areas?

BG Dunlap: Well, I heard about troubled relationships. But as far as my actual exposure, there was no conflict. Even later, when I was assigned to the Medical Field Service School we had a WAC staff adviser come over from Fourth Army headquarters to be our guest speaker in our Army Nurse Corps Basic Course. She talked about women in the Army. Then the basic nurses could better appreciate the role of the WACs at that time. [Major] Betty Clarke was one of them. She later became Major General Betty Clarke. We always had the WAC staff adviser come over. There was no competition as far as we were concerned in those two assignments.

That takes me through my assignment at Fourth Army headquarters.

MAJ Gurney: What do you feel you took out of that experience at Fourth Army headquarters? This was probably your first staff position. What did you learn that you used later on?

BG Dunlap: Well, certainly organization and functions of the staff at a headquarters level. That certainly set the stage for my work on other staffs. The response in an emergency was another thing. Korea started during that time and we mobilized. We were in a big mess. We had to be able to identify the nurses who could be called up—the reserves particularly—the reserve nurses who could come on active duty to augment us. I learned the necessity for training—training, training, training. I won't go into uniforms because throughout an Army career, uniforms have always been a problem. Especially getting functional uniforms, attractive uniforms, and enough uniforms for our people. Throughout my career I've been aware of the problems that existed with uniforms. From the very first day I came in. I showed you in my 201 File—it took them a month to get me a complete nursing uniform. It may have taken longer than that.

Also, during this time I worked not only with the headquarters staff but also with the Surgeon's Office. I gained an appreciation of the AMEDD [Army Medical Department] team. Until this time, I'd been in a hospital. A hospital organization is a little different than a headquarters organization. The Surgeon; chief, Professional Services; and the personnel officer worked together quite closely. Naturally, I worked with the budget officer trying to budget my trips and justify some of those things.

Colonel Short encouraged me to go on to complete my undergraduate degree. It was through her efforts, and the efforts of many contacts, that I went to school. I'm saying contacts in a very positive way, not a preferential way. People knew me in that position. When my application went in to go for long-term civilian training at Incarnate Word College, the people at the college at least knew who that application was coming from. Of course, Colonel Short highly recommended me to be selected. And I was selected. I realized the need to go on to finish my education. When I came back from World War II, going to school was the least of my desires. I wanted to live. I wanted to have fun. I wanted to do fun things with my off-duty time. Having just returned to the country I had no commitment at that time to continue my education. It was working with Colonel Short, in that envi-

ronment, and contact with the nurses in The Surgeon General's Office that motivated me to go on to finish my undergraduate degree.

Incarnate Word College

So, in 1953 I was selected to go to Incarnate Word College. This was a forerunner to long-term civilian training programs that we had later on. The Army was selecting certain people to go to civilian universities. I think I mentioned that Inez Haynes and Nellie Newell and some others went to the University of Minnesota. The chief nurse at Brooke was [Lieutenant Colonel] Naomi Jensen. Gay Falcone, who had been the chief nurse at Fort Hood when I reported up there, was also assigned to Brooke. Joyce Thornton, who was a captain, and [Captain] Peg Maher, and [Captain] Phoebe Paul were also assigned here. I attended full-time for twelve months of study. I had been taking courses during my off-duty time to be eligible to complete a degree at Incarnate Word in one year. I needed two years, but they agreed to let me have one year. I promised I'd meet all their requirements in the twelve months, which I did.

From 1947, Sister Charles Marie and Sister Christiana came from Incarnate Word to Old Splinter Village at Fort Sam Houston. We sent a staff car after them. They came over in the afternoon to teach courses in nursing administration and ward supervision, so that Army Nurses could go even if they were on duty. They could take their supper hour to dash over for class. The nurses could work toward their degree. A number of our Army Nurses were able to complete their degrees at Incarnate Word through that type of program. Others of us were able to accumulate credits. Being on recruiting, it was kind of difficult for me because my busiest time was when the colleges and the schools of nursing were in session. I couldn't get to classes then. So I went to night summer school at San Antonio College. Incarnate Word had some nighttime public health administration courses too.

By doing this I was able to get those necessary hours to be admitted to Incarnate Word. Also at that time the National League for Nursing [NLN] gave a test. You could take this test in five areas. Then the college you were applying to could give you the number of hours' credit that they wanted to, based on the results of your test. Some people looked on it as if you were given credit for your three-year hospital nursing program. But this was not true. They didn't just give you a blanket number of hours because you were a graduate of a three-year school of nursing. You took the NLN test, and then each college could determine how many college credits they gave you. I got sixty at Incarnate Word. That was why with that test, plus the hours that I had accumulated, I still needed two years to complete the degree.

Six of us were actually selected. One had to drop out for health reasons. But the five of us stayed over at Incarnate Word and completed our degrees. This was quite an experience. We were more senior than those little freshmen. At that time you didn't have as many older women coming back to college as you have today. On our college campuses today a large percentage of them are women who have come back to school after they raised their families or they're starting a second

career. But then, we didn't have that. So the five of us really stood out. We were in sophomore English with all those babies. But the sisters at Incarnate Word College were tremendous to us. I can remember one, Sister Evangela, saying how much it meant to her to have us in her sophomore English class. We had lived a great deal of what was being taught in the class. She felt that not only were we learning but the students and, of course, she herself were learning from us. They were very good to us over at Incarnate Word College.

MAJ Gurney: Let me insert a question here. What kind of courses did you as a graduate nurse need to complete the program? Were they primarily liberal arts courses?

BG Dunlap: Most of them were the liberal arts courses. But also, there were things like history of nursing, public health nursing, public health administration, and chemistry. But I'd had chemistry. Santa Rosa was affiliated with Incarnate Word. Therefore, I had gotten credit for chemistry, sociology, and foods and nutrition through that program. Biology—I'm thinking of some of the courses that some of the others had to struggle through.

MAJ Gurney: So, it was the biological sciences and liberal arts?

BG Dunlap: Plus some of the nursing courses such as ward administration, nursing services, supervision, the history of nursing. We didn't need the clinical aspects of nursing. We had gotten credit through passing examinations.

We had some wonderful experiences there. (Laughter) But I won't go into them. I will give you one of them because it affects other experiences in the military. Each year they had a harvest festival. It was a fund-raising affair. They had a professional nurses club and I was president of that. The professional nurses club was to sponsor the bingo activity. I hate bingo. I never played bingo in the Army. You could never get me to a bingo party. And here I was, the president of an organization that had to sponsor the bingo party for that function. We had to get the prizes and designate someone to call bingo. One of the nurses over at BAMC [Brooke Army Medical Center] said, "Oh, we've got the best person for that over there. It's Captain George Hayes, a tremendous surgeon." Captain George Hayes later became Major General George Hayes. So he and his wife came over to the bingo party, and he called the bingo for the nurses over there that night. We had a tremendous time. Plus, I'm a nondrinker. But I had to go to the breweries to ask for donations of cases of beer for the bingo parties. So, I had a well-rounded education.

MAJ Gurney: Yes. You did!

BG Dunlap: This does illustrate the relationship between the college, the military, and the community—how they worked together in the community here in San Antonio.

In 1954 then, I received my Bachelor of Science in Nursing degree from Incarnate Word and received orders to go to Europe. Lieutenant Colonel [Agnes] Maley was the chief nurse in Europe. Lieutenant Colonel [Dorothy] Ainsworth who had been my chief nurse at Fort Chaffee was the chief nurse at the 98th General Hospital in Europe. At that time you received orders to go to Europe. Then the chief nurse in Europe assigned you to a specific station in Europe. Colonel Ainsworth asked Colonel Maley if I could be assigned to the 98th General Hospital and Colonel Maley did that. I was back with Colonel Ainsworth again.



Captain Dunlap at Camp Chaffee, 1949; below, officers gather at the Camp Chaffee Officers Club, 1949. Major Ainsworth is fourth from left; Capt. Jeanne Treacy is second from right; Capt. Mary Lipscomb, dietitian, is far left, rear. [Personal photos]





Unified recruiting team: 1st Lt. F. M. Johnson, Maj. Martha Moseman, Lt. Comdr. E. R. Leighton, Capt. M. Osone, and Captain Dunlap [U.S. Navy photo]; below, with student nurses at Wichita Falls General Hospital, April 1951. [U.S. Army photo]





Captain Dunlap, center, with nursing recruiters from the Air Force and Navy, Fourth Army headquarters, November 1952; above right, Lt. Col. Augusta Short and Major Dunlap at the International Congress of Nursing, Rome, Italy, 1955 or 1956; below, with Col. Floyd Berry, MSC, Hospital Administration Residents Course graduation, Fitzsimons General Hospital, 1960. [Personal photos]



Lillian Dunlap is promoted to lieutenant colonel by Brig. Gen. James T. McGibony and Lt. Col. Eileen Fitzgerald, Medical Field Service School, November 1962; below, at the podium, Medical Field Service School, 1962.
[Personal photos]





MUST (Medical Unit, Self-contained Transportable) demonstration site at Camp Bullis. A rare San Antonio ice storm conspired to make the MUST the hands-down favorite over traditional tentage, below, to provide a favorable environment for patient care! [Personal photos]





The faculty of the Division of Nursing Science, Medical Field Service School, sponsors Thanksgiving breakfast for students and faculty, November 1964. From left to right: Maj. Marjorie Varner, Maj. Alma Anderson, Maj. Catherine Betz, Maj. Edna Stappenbeck, Lt. Col. Lillian Dunlap, Maj. Alice Bender, Maj. Margaret Ewing; right, Colonel Dunlap as Chief, Nursing Science Division, Medical Field Service School, 1965.
 [Personal photos]



An Emerging Leader

Neubruecke, Federal Republic of Germany

MAJ Gurney: What city was that in then?

BG Dunlap: Neubruecke, Germany. It's closed now but it was a thousand-bed hospital at that time.

When I first went over in '54, the tour was three years. During the time I was over there they reduced the tour to two years. But those of us who were there had the option of staying the third year if we wanted to. I elected to stay the third year. When you go to Germany, you arrive into Frankfurt. Then you traveled by train to Neubruecke. Jokingly, people said, "Well, Neubruecke's at the end of the line." Well, Neubruecke *was* at the end of the line, way out in the country. Saarbrücken was at the border just three kilometers away. So the train stopped there. It arrived late at night. Lieutenant Colonel [Dorothy] Ainsworth met every nurse who was assigned to Neubruecke. She came down to the train station to meet them when they came in. She would find out if anyone on her staff knew the nurses coming in. If so, she'd invite them to go down with her to meet them. The first Sunday, or weekend, if possible, as soon after the nurse arrived, Colonel Ainsworth would get a group of nurses together with their friends and pack a picnic lunch in the back of her car. She'd take them for a drive across to Trier, up the Mosel, and down the Rhine picnicking along the way.

These are just some of the things that make a good chief nurse—a good leader. Immediately you're thrown into this faraway country and you're met by someone like that. She saw to it that you had an ironing board to use, an iron, anything you needed until your luggage got there. She made sure you were as comfortable as you could be. Of course, most of us had friends. But I had known Colonel Ainsworth before. She'd been my chief nurse. When I reported in to Colonel Ainsworth and she discussed my assignment with me, she said that she might be kind of tough on me. But she wanted to assign me to be head nurse of the dependent ward. You have to understand; this is my first time back in clinical nursing for a long time. I had been on recruiting when I left Fort Chaffee for three and a half years, plus a year in college. I'd been out of clinical nursing. So, coming back into the general hospital and into a head nurse position would be tough. I had a dependent ward with all of the hospitalized women except obstetrics and isolation. This ward had every clinical specialty. The 98th General Hospital was a medical center, and patients were evacuated there from all over the European Command for orthopedics, neurosurgery, neurology, ENT [ear-nose-throat], and radiology. So, I had medical, surgical, and at that time, the back end of the ward was pediatrics. We

had one big room with cribs in it for infant-size beds. Behind that, we had a nursery for some of the spina-bifida patients and some of the children with hydrocephalus and other children like that. She explained to me: "We have a head nurse down there who is going to be rotating and I'd like you to go down there and work with her. She is a tremendous nurse. But she is not an administrator. As far as patient care, there are no complaints about the quality of patient care. But there is much needed in the organization and administration of the ward."

BUILDING A WARD TEAM

It soon became evident to me as I went down there that the relationship between the physicians and the nurses was one of tolerance. I felt that the physicians did not respect the nurses as professionals who could contribute to total patient care. The physicians would come and go directly into the room and see the patients. Then they'd come out and write orders. They might not even see the nurse. They'd pull that little tab over indicating new orders were written there. Then they would leave. Because this was a multi-service unit, I had *all* the physicians coming down to the ward. Sometimes the physicians would tell patients something, and then the patients would tell the nurse the doctor said they could get up out of bed or they could do this or do that. But there was no order written. I think you can see the potential conflicts that could arise then. So, I insisted that when a physician came onto the ward, they'd come to the nursing station and then a nurse made rounds with the physician. We began to do that.

I'll use this example. We had a tremendous neurosurgeon who spent hours and hours and hours, as most neurosurgeons do, taking care of all the autobahn accident cases. They'd have head injuries, cervical fractures—all kinds of real bad injuries. But he never came to talk to the nurse. He would go and see the patient, write the orders, and take off. After we had worked together for a while we developed a system. We often received HNP [herniated nucleus pulposus] patients who were evacuated to Neubruecke. These were our disc patients. Hospital trains evacuated them to us because we had no helicopter evacuation. We had a hospital train running in Europe at that time. The train would usually get in during the evening. This neurosurgeon wouldn't come down. We notified him that he had patients in, but he wouldn't come down to see the patient that night unless we asked him to. He would wait until the next day to give nursing an opportunity to observe the patient and the patient's activity. We'd watch them as they got in and out of bed, and as they moved around the ward. This gave him some indication of the patient's severity. If it was someone who was complaining of low-back pain, but she was up running around the ward and visiting with all the other patients, then it became evident that maybe hers wasn't quite as acute as some of the others. But he depended on the nurse's observations in helping him then when he made his rounds.

Our chief of Medicine was the ward officer. We had a ward officer who was responsible overall for the ward even though we had a multi-service unit. Colonel Ted Bachrach was our ward officer. We still correspond. He was so

wonderful. He could smell a diagnosis. The patients came in. He would talk with the nurses. Then he'd go in to talk with the patients and do his examinations. Naturally, he'd order the laboratory and x-ray tests that were necessary. But he could smell a diagnosis. (Laughter) Really. He was just that good. That's the way I used to put it.

Our chief of Surgery was the chief of Professional Services, Colonel Robert Kamish. I had known him at Brooke. Colonel Kamish was a tremendous surgeon. He brought the young surgeons being assigned to Neubruecke down to Ward 8 to make rounds. Ward 8 was the dependent ward. He introduced them to the nursing staff. He said to them, "The nurses can make or break your career." He meant it very sincerely. He said, "If you work with your nurses and depend on your nurses, then you will find that your career will be much easier for you. They can help you."

MAJ Gurney: Was this a change? Did this change come about after you took over the unit?

BG Dunlap: I don't know what had happened. But I know the relationship between the physicians and the nurses changed to one of professional respect and collaboration. We talk about being colleagues, and I think it was really developing at that point. Because the doctors read the nursing notes. Before, they didn't pay any attention to the nursing notes. They began to read the nursing notes, and we made rounds together. When they came in, I or one of the nurses would be available to make rounds with them. We'd stop what we were doing to make rounds with a physician. We could discuss with the physician our observations of the patient. He could ask us any questions about the patients. The two of us were at the patient's bedside together. The patient, the physician, and the nurse really had the benefit of the same information and planning. We worked together informally planning for that particular patient's stay there in the hospital.

Colonel Kamish impressed on these young surgeons that this relationship was important to their success as a physician. Otherwise they would miss things about the patient's condition because they weren't there to observe them. If they worked with their nurses, their nurses would be making these observations and would share them with them. It would help them in their treatment of the patients. We developed a real beautiful professional relationship. I won't say one physician's name, but he walked down the long hall of the ward and came inside the door, and he announced, "I'm here." (Laughter)

MAJ Gurney: What else did you do to help nurture that good relationship with the doctors?

BG Dunlap: I brought our NCO into the team. Sergeant Overstreet was a tremendous NCO. It was at this time Colonel Ruby Bryant was Chief of the Corps. During this time they published AR 40-6, which put enlisted nursing personnel under nursing service. Until this time the enlisted personnel were assigned

to the detachment commander, then later assigned to the wards. But if the detachment commander ran all the rosters and he needed someone, my wardmaster was going to have to pull NCOs to do it. The detachment commander had control over them. I didn't. People wouldn't show up for duty. They had this detail or that detail. We'd tell them we only had two corpsmen scheduled for duty but that was just too bad. They had to go to be CQ [charge of quarters] or something else like that over in the detachment. But this change in the regulation was approved. Its implementation was resisted a little as you can imagine. They didn't want our enlisted personnel to be under nursing's functional control. If we had them assigned for duty, our nursing service came first.

It didn't come that easy. You have to look at it from both sides. The detachment commander had certain functions he was responsible for. It could be KP or CQ or things like that. He wanted to control them. We had the function of nursing that we were responsible for. Therefore we wanted control of them for the time that they were scheduled to be on duty. We did not want control of them other than for their nursing function.

It took a lot of close working and understanding between our detachment commanders and our chief nurse and head nurses to work these things out.

MAJ Gurney: What was the physicians' position on that issue?

BG Dunlap: As a group, I don't know. Individually, some of them said, "Well, finally, they've wised up." The physicians didn't make rounds on the wards so they may not have been as aware of the issues. We didn't have the enlisted personnel on the wards to take care of the patients. We sure didn't have as many as we should have. We had to get people to x-ray. We had to get patients ready for evacuation back to the States. They had to be prepared to travel on the hospital train to send them for evacuation. It was things like that. Many of the tasks we needed to do had to be delayed because we didn't have the enlisted staff to do them. Once they came under nursing service for functional supervision, things changed.

Unfortunately, nursing is primarily women. Most of the enlisted personnel were male, so there were some conflicts as you can imagine. Some of the head nurses were pretty rough, stern, not very understanding. The enlisted men resented it. They didn't want to be bossed by a woman. They'd rather be bossed by a man, preferably the detachment commander. The rationale was to fix the staffing problem.

MAJ Gurney: How did you overcome the attitudes of the enlisted folks that they didn't want to be "bossed" by a woman?

BG Dunlap: First of all, I didn't boss them. But that's a perception that so many had. "Those nurses were going to be my boss." We tried to establish a relationship on our unit that there wasn't a boss. I'll give you an example. We had German nurses, civilian nurses who functioned at the nurse's aide level because the German nursing preparation didn't meet our standards. So, they were employed as nursing

assistants or nursing aides. Some of them were very good. I still hear from some of them. Rosie Krammer was one of them. We also had German doctors working in the hospital, too.

I can remember little Doctor Roth coming to me one time and saying; "You're too good to the German nurses." "What do you mean I'm too good to them?" We had a schedule request book on the ward. If you wanted certain days off you put your request in the book two weeks in advance. If it was done in advance, I had it available for when I made out the time schedule. I would try to honor the individual's request. After all, we were over in Germany. Folks could travel and see things. Their friends on other wards would also try to get off. The German doctor said, "You're too good to them." This was because I would ask the German nurses what they want. In the German culture, they were used to being told what they would do. So Dr. Roth was telling me, "You're spoiling them." Well, I kept on spoiling them. I was trying to develop a team feeling on that ward. It was difficult enough with the types of patients we had to take care of. We really worked together as a ward team there: our physicians, our professional nurses, our enlisted personnel, and our German personnel. When we had any ward functions, everybody was included.

I had two little black nurses assigned to me—Millie Davis and Vernice Elam. They were little lieutenants. I was a captain. I became a major while I was over there. They loved cooked fried chicken and corn bread. I also love fried chicken and corn bread. They would invite me up to their room to eat with them. If I couldn't come, they'd fix me a doggy bag and have it outside my door when I came home in the evening.

Neubruecke was isolated. It was way out in the country, so we made our own entertainment. We finally got a bowling alley. I think it had four lanes. We organized bowling teams in the hospital. The military police had one. Physical medicine had one. And the ANCs had a bowling team. Of course, our team was all women and this was a riot. We were in this bowling league playing against the men. Particularly when we had a bowler like little ol' (pause)—her name wasn't Dot—Haughton, Jean Houghton. She later became chief nurse at Fort Devens and at Fort Leavenworth. She was a little lieutenant and she was just learning how to bowl. She'd walk up to the foul line and barely drop the ball and push it down the lane. It would go down slowly. Then, all of the pins would tumble—one, two, three. On the other hand, here was a great big ol' 6-foot MP who would get up to the lane and he'd throw the ball down. And he'd have a split. (Laughter).

He'd throw it with such force and end up with a split. We had so many good times. We had officers and enlisted, men and women, all from within the hospital bowling together. Our women's team went to the Europe finals at an Air Force base near Munich. We didn't win but we sure had a good time going down there to represent Neubruecke in the bowling tournament.

This was spirit—leadership. Colonel Ainsworth was the chief nurse when I got there. Then Lieutenant Colonel Gunn, who had been in New Guinea with me, became chief nurse. Her name was Francis Cecil Gunn but we called her Cecil. Then [Lieutenant Colonel] Georgia Lessley was chief nurse for a short time

before I left. But I think you can again see how paths crossed throughout my career. Someone who had been my chief nurse would reappear as my chief nurse elsewhere. I was able to continue to serve with them and learn from them.

That was the spirit that we had at Neubruecke. We really made our own entertainment out there. We worked hard, hard, hard because we had all kinds of patients coming in and many were very sick. We finally were able to separate the pediatrics from the back end of the ward and we set up a pediatric ward parallel to the dependent ward. Then I had responsibility for both wards as head nurse. I also had the experience of working with personnel of a foreign country because when we first got there in '54, we were still under occupation standards. But then the Status of Forces Agreement was signed, and that is when we really saw changes in how we managed German personnel. The German labor representatives in our hospital in personnel were telling us how the German personnel would work. For example, I had a German nurse who was pregnant. She had a certain amount of time off for maternity leave before and after she delivered the baby. If she had twins, she had more time off than if she just had one. If she nursed the baby, she had more time off than if she bottle-fed it. We had one when I worked in pediatrics. She had all this time off. As a result, the other German nurses weren't able to get their leave in. So, when the one who had had her maternity leave came back to work, I scheduled Ms. Hahn to have her regular leave after that. But when the nurse who'd had the baby came back to work, she wanted her regular leave. I said she couldn't have it because she'd been off a long time and Ms. Hahn needed to have hers. The German personnel representative told me that the new mother *would* have her annual leave. I learned that our system wasn't so bad after all. (Laughter).

I learned to work with them because I had to depend on them. The German women who worked on Ward 8 were tremendous. They really were. One problem in a hospital is always custodial service. In those times, back in the States, it was our corpsmen who did the work. They cleaned the wards and the patients helped them clean the wards. In Germany we had "putzfrauen," German cleaning ladies. We had one little ol' German lady to clean that ward. I tell you, she took such pride in keeping that ward clean.

MAJ Gurney: I was going to ask you. It had been about a five-year break since you'd been in the clinical area. How had nursing changed in that time?

BG Dunlap: I didn't know the drugs that were being given. So many of them were new drugs. I had to study. I had to learn equipment—but particularly it was the drugs I needed to study. There were hypertensive drugs that we hadn't used before. The tranquilizers were new. That's when Thorazine was being used. There were drugs like that, like Thorazine and some of the others. It was not only the adult drugs that were different, but also the pediatric drugs.

I really studied everything that I could get my hands on. I also asked a lot of questions of the physicians, of Dr. Bachrach and others. Colonel Kamish was specializing in cancer therapy. Women who had mastectomies were sent out to Neubruecke for radiation. Colonel Kamish was doing a study, I guess, you'd call it.

He felt that women who'd had mastectomies should have oophorectomies also before they started the radiation. So, as the patients came in, he would wait until the husbands got there. So many of these women came in by hospital train at night. Sometimes the husband didn't get in until the weekend—whenever they could get away from duty. A lot of them were from all over Europe and many were on maneuvers most of the time.

He'd have the husband and wife together; then he'd discuss with them what he would like to do. It was his theory that they should do oophorectomies on the women. This was to reduce the chance of them having a malignancy later on in the ovaries or the uterus. He was always so tender. Do you talk about a man being tender? But he was. And he was kind. Particularly if it was a woman who was still in the childbearing years. He'd explain what this meant for her. It would be up to the husband and wife—as to whether they'd go ahead and do an oophorectomy on her. I never knew the results of his study. I don't know if he was able to follow through to find the number of patients who had recurrences of cancer as opposed to a control group that that didn't have the surgery.

Also, it was there at Neubruecke that the chief of ENT heard about stapes mobilization for deafness. Lieutenant Colonel Sheehey was an ear-nose-throat physician. We had a couple of nurses who had hearing losses. They weren't completely deaf but they had hearing loss. He did this procedure on them. One of them lives here in San Antonio—[Major] Fran Priddy. I'll never forget it. The procedure was done under local anesthesia. I got to go into the operating room with him when he did this. I'll never forget it. She said, "Oh, my gosh. I was better off when I couldn't hear!" The helicopters came in over the wards to land on the pad right out front. They made such a terrible noise. These nurses were very hearing-sensitive immediately after they'd had their surgery. He had learned how to do it. Then he practiced down in the morgue. He did several cases there. Years later my sister had that same operation.

FIELD TRAINING

During this period of time we were very much aware of training—field training and preparing for invasion. The nurses had to rotate through the operating room to scrub. We also rotated through anesthesia and OB [obstetrics]. We had one OB physician. He was an American obstetrician of German descent. When he lectured it became quite a joke. "Have you got your shoestrings on?" His story was that in case you're out where there's a delivery you can always use your shoestring to tie the umbilical cord. So, this became a joke. When we'd get dressed, we'd be sure and wear our shoes with shoestrings in them. In case we had to use them.

We worked this training into our regular time. We'd be scheduled to be a week or two weeks in these areas for observation and a minimum of specific experiences like scrubbing. We might be second scrub on a case.

We also had to support the field maneuvers going on at the time. We had quite an experience at Neubruecke. A group of us were sent out in the winter-

time, up to around the Fulda Gap, to support maneuvers. We did not have winter uniforms. The field uniforms we had were the summer field uniforms. We didn't have liners and the woolen clothes and all the rest. We nearly froze to death over there. It was so cold. We set up our hospital and functioned. Then we moved down near the hospital at Wuerzburg. It was built into the scenario that the hospital was going to have to pull back down near Wuerzburg to set up down there. I'll never forget the night that we set up there. We wanted to get set up as quickly as possible to take care of patients in case they started coming in. The nurses pitched right in to help with the other personnel—the enlisted personnel setting up the tents. We were actually raising the tents and holding the ropes and everything else. The nurses' quarters were one of the last things to be set up. But we were so cold. Finally, they took us in to Wuerzburg to the hospital where we could at least take a warm shower and get some warm food. I don't drink coffee—never have. But I went to the mess hall and filled my canteen with coffee so that I would have something nice and warm. Then I put the canteen in my bed. (Laughter)

It was my hot water bottle so I could warm up. (Laughter)

We also had the hand warmers inside our gloves. They were little packets we could put in there. We had brought some of those with us. One problem we encountered on maneuvers was to get our physicians to participate. Not all of them were a problem; many did treat it as if they had real patients. But some of the physicians didn't want to come over when we'd get patients in at night. They didn't take it seriously. I think you will find in the history of maneuvers that that was one of the criticisms in all critiques that came out. There was a problem making it as realistic as possible and to play the game. I've been on other maneuvers like out here at Camp Bullis where it really was very realistic. They really got into it. But when you pull your staff from not one unit, but many different units, you find many of them didn't want to come in the first place. Then, put them out under those severe conditions. They didn't play the game and take the maximum advantage of the training that they could have. Not only do you need the physicians to play it more realistically, but you need them to teach the nurses and the enlisted personnel. They could teach about treating frostbite or something like that. This issue is true at all levels, but we particularly had trouble on that maneuver with the physician group.

Lieutenant Colonel Ruby Bryant was chief nurse in Europe by that time. She had been Chief of the Corps. But you may remember we only had one slot for a full colonel. That slot went to the Chief of the Corps. When she completed her four years, then she reverted back to lieutenant colonel and came to Europe as chief nurse in Europe.

I prepared the after action report for that maneuver for the group from Neubruecke and I gave it to my chief nurse. It went on to Colonel Bryant because we felt that we weren't getting the most benefit from the training that we should. Certainly the field clothing for the women had to be looked into. We should not be sent out in freezing weather with our summer field clothing and summer sleeping bags.

MAJ Gurney: I've experienced that too. Besides the specific maneuvers that you were on, was there other training for the hospital staff related to field subjects and field medicine? Or was the training that you did back at your unit at Neubruecke simply concentrated on clinical topics needed for fixed hospitals?

BG Dunlap: We had both. Our people went out on maneuvers. All the enlisted and officer personnel went out on different maneuvers like that. They'd pull a certain number from each hospital. We would set up a hospital down at Hauptstaden airstrip, which was just down below Neubruecke hospital. One day our hospital would have to set up a field unit down there and function for one or two days. We also set up a bus because the plan at that time was to evacuate. How would we evacuate our patients if we had to? The idea was to evacuate to France. They set up one of the great big buses like they use for evacuation of patients. We set one up to use to perform minor surgery and delivery room functions. We had OB out there. It was possible we might have women who were in labor, or might go into labor, while we were evacuating them to France. So, we'd need to be prepared to take care of the deliveries. We had all the resuscitative equipment and other things in that particular bus. Then we also had the hospital trains that came into Neubruecke bringing us patients. We assigned different people to help with getting our patients ready to go on the train for evacuation to the States. Others would go to meet the trains to bring the patients in. We tried to get as much training as we could.

I wanted to talk about our clinical preparation in Europe. We were being cross-trained over there in case of emergency. We cross-trained so we could fill in in the operating room or in obstetrics. I talked about preparing for the evacuation of casualties and then about the field. We also had alerts the whole time that I was in Europe. The alerts were not announced. The purpose of the alerts was to see how many people could report for duty within a certain period of time once the alert was called. Since there was a restriction on the number of people who could be away from the post at any one time, we still needed to know this. And, naturally, they did not call the alerts at 5:30 in the afternoon, or when people would normally be around and on duty. We'd have alerts at 5 o'clock in the morning, or at any time during the night. Someone would be sent up from the hospital to the nurses' quarters to call the alert. There were alerts throughout Europe and those just for our hospital. So, it could happen in two different types. For the Europe alert, we were to report to our place of duty in field uniform ready to go if we had to. As far as the hospital one, we had to report to our place of duty, period. It was just to determine within our hospital how many of us would be on duty if the alert had actually been called and patients started coming in. Well, naturally, we'd get into the uniform which was the most convenient one for us to get into. It was always quite interesting to see how people appeared for those alerts. Some of the nurses arrived with rollers still in their hair and a handkerchief tied around it. That didn't happen very often. You couldn't get by with that. (Laughter)

But we were constantly on the alert because we never knew when these were going to be called—a usual alert or a hospital alert. The whole purpose again was

to determine that if something happened, we would have enough staff there available at that time to take care of the patients we had. Because the plan was to evacuate those patients, a question was, would we be able to evacuate those patients and be ready to receive new casualties within a short period of time?

We were constantly being prepared, trained to function in a time of an emergency. Particularly, our emphasis was in terms of uncovering the ability of the hospital to function effectively in the time of emergency.

MAJ Gurney: You went through generalized clinical training in your facility. You experienced alerts and practiced mobilization. For you, mobilization included being prepared to move patients and empty out the hospital in preparation of receiving new casualties. Then you also mobilized for field exercises.

BG Dunlap: We were all assigned to a field unit in Europe. It may have been a paper field unit. But we were assigned, so that if the whistle blew, there were nurses and doctors and enlisted people who would join that unit and set up in the field someplace and function.

I don't know what happens in Europe now, but they were continuing with a good deal of that type of readiness planning. '74 was the last time I was in Europe. It was modified different ways with budget restrictions and different constraints. But the whole idea remains that the people over there have to be able to respond if something happens.

MAJ Gurney: Was it difficult for the hospital to manage this on top of regular patient care? It seemed that they were involved in a lot of training. They also had a lot of their staff out to field exercises. Was it difficult for them to maintain regular patient care on top of all of that?

BG Dunlap: At that time we may have thought so. But as I look back on the total picture, that was what we were expected to do. And we did it. It's just like leave policy. Only a certain percentage of our staff could be away from the hospital on official leave in the event that we had to quickly respond to some action. Another percentage must be within a two-hour driving time from the hospital. A percentage could be away, but they must remain within two hours' driving time.

TRAVEL IN EUROPE

That was not always adhered to. (Laughter)

Neubrucke was way out in the country. It took two hours to get anyplace. It'd take you an hour to get into Baumholder. Colonel Ainsworth, being the wonderful chief nurse she was, recognized that, and our commander recognized it too. Therefore, they would help us out. One of our physical therapists was one of the champion tennis players in Europe—[Captain] Ethel Coeling. If she wanted to go down to Garmisch because she was in a tournament down there, and we wanted to go down to watch her, they would let us. Or, if we wanted to go to

Heidelberg for the “burning” of the castle, that was more than two hours away from our post. Colonel Ainsworth would have us sign an official leave form and she would keep it in her desk. If anything did happen then we’d be covered. We’d officially be “line of duty—yes”. That enabled us to do some of the things we’d have to drive a distance for.

I’ll tell you one experience we had. HR [Captain Hattie R. Brantley] was with me. We drove down to Heidelberg for the burning of the castle. You’ll remember that’s at nighttime. It’s such a glorious experience to watch it. When it was over we came back to Neubruecke. Neubruecke is way out in the country with lots of winding roads. At that time the roads weren’t as good as they are now over there. The autobahns were good, but the other roads weren’t. We were on the autobahn and we saw an accident ahead. We pulled over to the side. It was something you saw on the autobahn so often. They had put those barrels out to divert traffic to one lane, or move traffic from one lane to close that lane. Some of the people speeding on the autobahn didn’t see those barrels and ploughed into a bunch of them. We jumped out of the car and went up there to see what was going on. One individual, a woman, had been decapitated. Another was quite seriously injured. I immediately ran back to my car. HR will tell you how I lost my nice comforter that I had in the back of the car. We used that to cover up the individual who had been decapitated. We stayed there and as traffic began to build up we got someone to direct traffic to slow them down so they wouldn’t be bumping into us. Eventually they got the military police and the ambulances out to pick up those who’d been injured. That was quite an experience. It was difficult to drive from there on back to Neubruecke that night over those terrible, foggy roads. In Germany you could be on a beautiful clear road and then suddenly there’s a patch of fog. You can’t see anything. There was so much of it out in the Neubruecke area because it was countryside. Then, we had to go on duty the next morning.

MAJ Gurney: That was hard.

BG Dunlap: Yes. But if Colonel Ainsworth hadn’t covered for us we wouldn’t have been able to go down to see the burning of the castle unless we were on official leave.

I loved Switzerland. I was down there six times. I tried to climb the Matterhorn. When I first got over there we had a PT [physical therapist] and a nurse anesthetist [Captain Mary O’Carroll] who were talking about climbing the Matterhorn. “Lil, will you climb the Matterhorn with us?” So, for a year we talked about climbing the Matterhorn. We went down to Zermatt and we climbed awhile. We didn’t take it seriously, but we wanted to see what we could do. We had a tremendous time down there. That’s why that painting I have in there is of the Matterhorn. It has that little hut down there. It means so much to me. That’s the type of a little hut that we stopped in to get our breath. That was painted by the wife of Colonel Manley Morrison who later was chief of the MSC [Medical Service] Corps. She did it when he was stationed in Germany. My friend over there, Irene Pishak, knew how I loved the Matterhorn. So his wife painted that

picture for me. I can just see us sitting down there in that little hut trying to catch our breath before we climbed up some more.

I had a wonderful three years in Germany. I won't go into all of the sightseeing and tremendous experiences we had. I would never have been able to travel to Europe and see and do the things I did if I hadn't had that three years over there. My last year my mother came over. She and [Major] Joyce Thornton, who was chief nurse at Bremerhaven, and her mother, and I drove through Europe. I met Mother in London and we froze. She couldn't find iced tea anywhere. (Laughter).

But we drove all through Europe and had a wonderful time. The rest of my mother's life she talked about her trip to Europe as if it were just yesterday. It meant so much to her.

RACIAL INTEGRATION

MAJ Gurney: Could I switch gears just a second to ask a couple of questions that have come to mind as you've been talking? As you worked at Neubruecke you had two black nurses who worked with you. When you were in the Southwest Pacific and during that period of time, black soldiers and nurses were segregated from the white soldiers. This was true of nurses and physicians also. After the war they were integrated. What was the impact of this integration on you? What were your perceptions?

BG Dunlap: Well, I was aware of the segregation even when our unit was on desert maneuvers at Camp Young, California. There was a Signal Corps unit that had black soldiers, but the officers were white. Some of our nurses went with the white officers. And when we went down to their unit to their—I guess you'd say their officers' club—we'd be very much aware of the fact that the guards challenged people, you know, about going into certain areas. When we were there we were in an area where there were all black soldiers except the white officers. We did not have that in the hospital setting like that. I didn't really encounter that.

MAJ Gurney: Was there increased security? Or the separation of black and white?

BG Dunlap: There was not increased security, but there was separation of the black and white. We'd never had a black nurse. I can't remember a black nurse in any place I'd been assigned until I reached Fort Hood. There, we had [Major] Mary Welbourne. She was an operating room nurse. Later, she was with the 141st when it went to Korea. She was later my operating room supervisor when I was chief nurse in Okinawa.

MAJ Gurney: She was the only black nurse at that unit?

BG Dunlap: I'm trying to think if we had any more up at Fort Hood. We had a problem at Fort Hood. Hood is isolated. It was really isolated then. Not everybody had cars. When we wanted to go into Killeen, Temple, or Waco, particularly, we

didn't think anything about looking at who's off duty and might want to go. "Jump in, we'll all go." But when we got into town and parked the car, the black nurses went their way and we went our way, to do the shopping and the eating we wanted to do. They weren't able to shop and eat in the restaurants as we were. The blacks had to eat in the back room in a lot of places. They had special entrances for them.

That was even going on here in San Antonio in 1960. I can tell you about that later when I get to MFSS [Medical Field Service School].

MAJ Gurney: By the time you got to Fort Hood the medical portions of the military service had been integrated. The impact was particularly felt when you left post.

BG Dunlap: Yes. In this part of the country, and particularly up in that section. Because you didn't have integration up there. Now, over in Germany it was different. I didn't feel it. We did travel together over there. I guess there had been so many black troops during World War II over in Germany that I can't remember feeling the impact of integration. I had two black nurses on my ward. We had another black nurse who worked down in the male orthopedic ward. Her name was Jefferson. These three black nurses were the most tremendous professional nurses. The two on my ward were young lieutenants. But they were good nurses—real professionals. And they worked. We had a black orthopedic surgeon come into the staff there. All of them were tops professionally and good people.

We did things together. If we were going to go to Kaiserslautern or down to Landstuhl, that was a big trip. Well, whoever's going, come on. Let's go. So, I didn't feel it at that time.

MAJ Gurney: At Fort Hood when the concept was still fairly young, what were the attitudes of the nurses?

BG Dunlap: We lived in the same nurses' quarters. Mary—and I'm trying to think, she wasn't the only black nurse, there may have been two or three. We all lived in nurses' quarters. They were accepted. She was a tremendous OR nurse. If we wanted to go any place off post, they were included. They were with us in our social functions and things we did. But then, when we went off post it was a rude awakening to us—the whites—that we couldn't go into the restaurants together. Or we couldn't go shopping together. They didn't want to embarrass us. If one of the blacks went with us into one of the stores in Waco, it was very likely the saleslady wouldn't come wait on us. They didn't want to put us in that situation.

INTERNATIONAL CONGRESS OF NURSING

BG Dunlap: I had the opportunity while I was stationed at Neubruecke to go to Rome to the International Congress of Nursing. Lieutenant Colonel Ruby Bryant, the chief nurse in Europe, was very anxious for as much representation as could

get leave to go down to Rome to attend it. A group of us went from the different hospitals in Europe. That was my first experience attending anything like that that required translation. We sat there with our earphones on while they were speaking up there in French. The French don't ever speak in anything but French. Even though they were speaking in French, it was coming to us in English. I met Sister Olivia who was the dean at Catholic University. She was down there attending. Sister Charles Marie from Incarnate Word was there. I remember as we came out of the sessions there were little sidewalk places where we could stop to get an ice cream or something cold to drink. Of course, the nuns didn't have money to spend. So, "Sister Charles Marie, wouldn't you and Sister Olivia like to have——?" And we'd offer them ice cream or drinks.

We had a civilian nurse working in Europe who had a little tiny Fiat convertible. When we'd get ready to leave the meetings at the congress to go back to our hotels, we'd pile in her little ol' convertible. We'd put Sister Charles Marie and Sister Olivia—any of them who might have been there at the time—right in there in the back seat. That's when they still wore those habits with the flying wings we called them. So we'd go flying down the roads and avenues in Rome. We'd pull up to the hotel and many of us would pile out of (Laughter) the little car.

Most of us had driven to Rome. We had taken things to have a reception for the Army Nurses who were going to be attending the congress. We carried it all in the trunks of our cars. [Lieutenant Colonel] Eileen Fitzgerald, [Lieutenant Colonel] Ruby Bryant, [Lieutenant Colonel] Harriet Dawley, [Lieutenant Colonel] Graham Price, [Lieutenant Colonel] Eileen McCarthy, [Captain] Zita Ireno—a bunch of us were there. We'd taken all these different things that we'd gotten at the Commissary so that we could set up a buffet in our room and have our own open house for the Army Nurses who were coming down. We also invited our civilian American nurses to join us.

So, that was my first experience at an international meeting. My first American Nurses' Association Convention was when I was at Fourth Army headquarters with Colonel Short. I went up to Atlantic City to the convention. It was at this time that we had the five nursing organizations. Then the vote was taken to combine into two—the ANA [American Nurses' Association] and the NLN [National League for Nursing]. Prior to that time we had five. That was quite a landmark in nursing, and I felt privileged to be a delegate from San Antonio to participate in that at Atlantic City.

While I was in Europe, [Major] Harriet Werley sent a questionnaire out to us. She was interested in getting Army nursing research started. She sent a questionnaire out to the nurses about nursing research. I think that out of these questionnaires came some of the direction that our nursing research program at WRAIR [Walter Reed Army Institute of Research] took in the years to come. To my knowledge, that was really about the beginning period of nursing research in the Army. Harriet Werley was the one who had started that. I had worked with Harriet when she was a captain here at Brooke after I came back from overseas.

I don't have to tell you I had a tremendous three years in Europe. I learned a great deal, not only in the clinical area, but my head nursing experiences were

tremendous. And I learned about the world and the people of the world, how blessed we are to be Americans and to live here. Colonel Haynes—Inez Haynes—came to Neubruecke as she was touring the stations in Europe, and she talked to us about career planning. You'll remember I had not had basic training when I came in. They didn't have basic training then. She was talking about basic training. She also talked about the career courses that they were trying to set up. I told her, "Well, I didn't have basic. I haven't had the career course. What on earth are you going to do with me?" When I returned I put in my preference statement—those famous preference statements—that I wanted to be stationed any place in the United States that was near a college offering a master's degree in nursing. My orders came through for me to go to Fort Jackson. This is before Colonel Haynes was in Europe. Fort Jackson—the whole state of South Carolina did not even have an undergraduate degree in nursing. Amy Viglione was in the process of setting up the undergraduate program at the University of South Carolina. There would be no opportunity for me to go on then to work on my master's degree. So I wrote back to the chief of the Army Nurse Corps Assignment Branch and brought that to her attention and asked if they would reconsider and send me any place in the United States where I could work during my off-duty time toward my master's degree. I received a letter back saying she knew I would enjoy my assignment at Fort Jackson. (Laughter) Lieutenant Colonel Hannah—Elizabeth Hannah, who'd been chief nurse at Fort Hood—was looking forward to me coming and joining her at Fort Jackson. I told Colonel Haynes this and she got out her little book, as chief nurses do when they do staff visits. Colonel Haynes made some little notes. (Laughter)

Fort Jackson, South Carolina

When I reported to Fort Jackson, Colonel Hannah told me she had received a phone call from Colonel Haynes. Colonel Haynes wanted me to call her. So, I called her. She told me that I could either go to the hospital administration course or I could go to a civilian course for my master's in nursing administration. Which did I want to do? I had never heard of the hospital administration course. I knew absolutely nothing about it. I said, "Well, let me find out a little about this first." So I found out about as much as I could about the hospital administration course. My decision was that I would like to come to Fort Sam Houston to attend the Army-Baylor Hospital Administration Course. This was in October of '57. She said, "Fine, put your papers in." I put my papers in. I stayed at Jackson until June of '58, and then came on down for the hospital admin course.

At Fort Jackson I was assigned to the medical section. I was only there from October until June. During that period of time, I was in the clinical area again. I was a head nurse of an isolation ward. We still had polio patients and iron lungs at that time. Therefore, we had the iron lung on our ward. We also had a lot of hepatitis. We had tuberculosis. And we had measles patients. It was at this time we had so many troops from Puerto Rico who came to Fort Jackson for their basic training. They had not been exposed to our type of three-day measles. We knew

when they had been out in the field because after the incubation period for the measles our wards were filled constantly with patients with the three-day measles. Some of these patients were quite ill. It was also at this period of time that we had the meningococcemia. They had flu-like symptoms.

PROGRESSIVE PATIENT CARE

Recall now, the old cantonment-type hospital with the long ramps that could be a third of a mile long. We might be covering one whole ramp or maybe even two ramps. As we made rounds, we might have an Army Nurse assigned to the ward. We always had civilian nurses working there, too, especially where we had the acutely ill patients. But then we also had the convalescent-type patients. We would have just the corpsmen covering those wards. We'd make rounds to these different wards, and an awful lot of training went on. We had to look for the symptoms like the petechiae. We'd look for temp elevation. We'd train the corpsmen to look for these little things and to immediately report them to us so we could transfer the patient into the acute care area. We had many sick, sick, sick patients there. We had some deaths. I don't know how many. But some were in intensive care for a long period of time.

MAJ Gurney: What did you do for these patients?

BG Dunlap: For these patients, we could give antibiotics. The patients had upper respiratory-type infections. Some had to have oxygen. We also gave aspirin for temp elevations. We forced fluids. There was a lot of the nausea and vomiting. We had to be concerned about their electrolyte balance.

MAJ Gurney: You described sending them to an acute care unit. What was this unit?

BG Dunlap: It was just a ward that we put all our sick patients on. It wasn't an intensive care unit as we know it today. We did have some of those units. But we certainly didn't want to put these isolation patients in with the others because they needed to be isolated. So, we concentrated all of those who were acutely ill into one of the big wards. Beyond that, it was a progressive patient care concept, really.

MAJ Gurney: Did this unit have a different ratio of nurses to patients?

BG Dunlap: Oh, yes. We had to because these were such sick, sick patients. We'd have to watch them so closely. I said we had TB [tuberculosis] patients and hepatitis patients. We had a lot of hepatitis. A lot of these patients, after they got over their acute stage, they had many chest complications. I can remember doing postural drainage in one of those big open bays. We'd try to teach a patient how to do postural drainage but they wouldn't do it. It isn't a pleasant thing to do. Talking

about a mass production or assembly line, at a certain time we put the paper towel on the floor beside the bed, the corpsmen would be working with us. We'd put the emesis basin down on the floor. Then we got the patients to hang over the side of the bed and cough and cough, to cough the stuff up. We'd have a whole ward full of them down there. "All right. Everybody cough!" (Laughter)

MAJ Gurney: Did they include percussion and vibration, too?

BG Dunlap: Yes. Yes. Absolutely.

MAJ Gurney: So, you were clapping and everything?

BG Dunlap: We were working with all of them like that all the time. I can see those wards now. You know how it is in the Army. The GIs are so tremendous. You'd really make jokes out of it as you went through something like this. But it wasn't a joking matter. It was only when we had the staff who really took this treatment seriously, and would do something like this, that we could see the difference. Once they got into another ward and they didn't have that type of care, they didn't clear up as quickly. It was an important part of the treatment.

MAJ Gurney: The nurses who worked on the acute care ward, did they have any special training to do what they did?

BG Dunlap: No. No. You know my background in nursing. Certainly I hadn't worked isolation.

MAJ Gurney: So it was considered more an isolation unit than perhaps an acute care unit?

BG Dunlap: They called it a contagion unit. But the whole thing is just the common sense you would use in progressive patient care. We put our sickest patients together so that we had an RN on that ward each shift. But during the daytime we might have more than one RN on that ward. As their condition improved, they progressed to the second ramp, or to the third ramp—farther away from the center of the care. We moved them to what would be referred to now as intermediate care. Back at the second ramp, I might have professional nurse coverage in the daytime and possibly the three-to-eleven shift, but not during eleven-to-seven. During night shift, one nurse covered a number of wards. Then later, patients went to the third ramp. There they were really self-care patients. I can remember covering medical wards on first, second, and third ramps. We had one nurse to cover all that area, which was quite a distance. But we had good enlisted personnel, and we really evaluated the enlisted personnel. If we felt that they couldn't handle the ward, we certainly didn't put them on. They might be the only enlisted men to cover the whole ward that night back in those areas. At Fort Jackson I had a great learning experience. One of the most effective, I think, to prepare me to be a chief nurse.

LEADERSHIP

Lieutenant Colonel Elizabeth Hannah was Fort Jackson's chief nurse. She was from Harrodsburg, Kentucky, the perfect Southern lady. She was a tremendous administrator, a beautiful person. She was quiet spoken, very effective. She accomplished the things that she wanted. We were never aware that there were any problems or any ruffled feathers or anything like that. From the commanding officer down to the junior private in that hospital, they did things for nursing service because of her leadership. They loved her. They respected her. Nursing service could get anything we wanted whether it was supplies, food service, anything. Remember, we were still serving food on the wards, cooking the breakfast and doing things like that. But anything that we needed, or any problems that we encountered, we could get what we needed.

Colonel Hannah was the chief nurse and [Lieutenant Colonel] Geneva Bowen was the assistant chief nurse. Those two ladies and leaders were really wonderful role models. I think of Geneva Bowen particularly in terms of counseling. I would call to talk to Geneva—I called her Gen. Then I'd go up to talk with her about a problem. When I left her office, I realized she didn't tell me anything—that I had arrived at a decision. (Laughter)

She would sit there. "Yes . . . Uh Huh . . . Hmm." She'd lead me into a decision with questions that drew me to discuss my problem with her. I arrived at my decision without her giving me advice as to whether I should do this or that. I'd walk out of there and I'd say, "That stinker." (Laughter)

But isn't it effective? That certainly helped me grow in decision-making and in counseling techniques. I could use those techniques in later years.

At the same time, we had an awful lot of fun putting the bicycles in the trunk of my little Opel station wagon and going down to Myrtle Beach and having a good time. We got sunburned and so forth. [Major] Eva Katowski was the supervisor of the Surgical Section; likewise, she was a tremendous supervisor. She lives up in Maryland now. But the supervisors and the chief nurse were certainly role models for us.

MAJ Gurney: What made them effective? Besides the counseling?

BG Dunlap: Rounds.

MAJ Gurney: Rounds?

BG Dunlap: How they make rounds in a hospital like that. There are rounds . . . , and there are rounds.

I'll give you an example of why it was such a learning experience. Colonel Hannah received orders to come to the AMEDD career course at Fort Sam Houston. A chief nurse who was the exact opposite of Colonel Hannah replaced her. She was a little bit taller than I am maybe. She was an Irish "biddie" from the Boston area, very much aware of her position and her rank. She talked in a loud voice. She issued us orders. I'll give you one specific example. I was supervising at

that time. I went down to the psychiatric unit. The nurse explained to me that the side door, a wooden door, was closed and locked. That went out onto the screened porch that the patients used. The reason that it was closed and locked was because one of the patients had knocked out the screen door and had torn up the screen. The nurse had called maintenance to come up to take care of it. But until they could get that fixed, they had to lock the door for security. This wasn't a closed ward, it was an open ward. But it still had to be locked. She said they said they'd get up there just as soon as they could. I said that's fine, but you keep on them. It wasn't a fire hazard; we had both front and back entrances. We could certainly have evacuated the patients if we had needed to. We were confident that just as soon as they could get up there, they would take care of it. Just as I was about to leave the ward, the chief nurse came in making her rounds. She wanted to know why that door was locked. The nurse explained, and I let her explain, why. She said, "I want that fixed now." She went to the phone, picked it up and called maintenance. "This is Lieutenant Colonel _____, your chief nurse. I want that door fixed right now. I want you to get your so and so up here and get that door fixed on this ward. And, if it isn't fixed within a certain length of time, I'll go straight to our commanding officer. He'll see to it you get that fixed."

What a difference between the two. We hesitate today to say difference in black and white, but that was black and white in nursing administration and supervision in a leadership role. I saw it so vividly. This chief nurse hadn't been there too long, and I could see the change in the attitude of the rest of the hospital toward nursing service. They'd do everything they could to delay doing what she told them they had to do. They would wait as long as they could. It was a reaction to the chief nurse. Because Geneva Bowen was still there, bless her, she was a saint to work under those conditions. The same nurses were there—most of them. There were some changes.

But I could see the change and how much harder it was for nursing to accomplish anything. They weren't doing it because of us, they were doing it to get back at the chief nurse. So, I've always said you can learn from negative experiences just as much if not more than you can learn from positive experiences. This was such a vivid example.

I was really involved in the clinical area at Fort Jackson, as you can see, and in this new area of contagion or isolation treatment. I was very involved and learned from those clinical and leadership experiences. Of historical significance, this was at the time that reserves were required to complete twenty years of service by the time they were fifty years of age, or they had to get out of the service. One alternative was that they were offered the opportunity to revert to enlisted status in order to finish their twenty years. [The requirement was later altered to require completion of twenty years' service by age 55.] We had two Army Nurses in that situation. Julia Gillespie was one of them. She was a major in the Army. But she could not complete twenty years by 55. So she became the rank of sergeant in the WAC. We kept her assigned to Fort Jackson. She ran the outpatient clinic just like she had been running it as a major. Some of the nurses that this happened to didn't have as understanding a situation as she did. They weren't

allowed to continue to function as an RN in their setting. But she finished out her twenty years then as a sergeant in the WAC. She retired in the highest grade that she had held which was as a major. I don't know if it was one or two years after that, they changed that if they couldn't complete twenty years' service by age 55, they would have to get out. It was very unusual but it was during the time I was there at Fort Jackson because she was head nurse of our outpatient clinic. She ran a beautiful outpatient service.

Army-Baylor Hospital Administration Course

PHASE I

MAJ Gurney: I have read Colonel Blanchfield's oral history. She says that after the Second World War, she identified the need for administrative training and education for nurses. It states that it was particularly at her urging that the course was developed. Originally, they were going to make it just a nurse course. She objected. She wanted it to be a combined course. Do you remember any of that? Did you hear any of that history?

BG Dunlap: I don't remember any of her association with the course. I don't know it that way. I do know that the original course was mostly nurses. There were others, but there were mostly nurses in that original group. I'm trying to think, but it may have included [Lieutenant Colonel] Ruby Bryant and [Lieutenant Colonel] Tib Barrett and a whole bunch of them. It was not affiliated with Baylor University at that time. It was in 1950 that [Brigadier] General Floyd Weigand was in education and training in The Surgeon General's Office. I wrote something recently about it. I sent information up to [Brigadier General] Connie [Slewitzke] for her speech. Then, Amy Freeman Lee asked me to help her with hers. Then the president of the college called over and wanted to know if I could help him with his. (Laughter)

General Weigand contacted Sister Charles Marie at Incarnate Word and asked Incarnate Word if they would evaluate the hospital administration and nursing administration courses that the Army was conducting so that Incarnate Word could give them credit for their courses. That was in 1950. I know that happened. But I don't know of Colonel Blanchfield's relationship to it. It certainly might be true. It did start out that most of the students were nurses. Some students were MSC.

MAJ Gurney: That tends to support what she said at that time.

BG Dunlap: The war was over in '45 and it was in '50 that this happened. It must have started before '50. At that time it might have been primarily nurses with a dusting of other Army Medical Department whereas now it is primarily other Army Medical Department with a dusting of nurses.

MAJ Gurney: Tell me about the curriculum of the school.

BG Dunlap: We had four Army Nurses and one dietician in our course. The four Army Nurses were Robena Anderson, a major; [Major] Nellie Newell, who later became the assistant chief of the Corps; [Major] Althea Williams, who later became a chief nurse at Madigan and in Vietnam; and myself. I was a major. The dietician was [Major] Barbara Kennan. We were the women in the class. Our class leader was Colonel Glen Collins. We had a number of MSC officers, just a very few doctors. Colonel Collins, of course, was Medical Corps. It was mostly MSC. There was no dentist or veterinarian. We had a number of young Air Force officers. One of them was First Lieutenant Don Wagoner, who later became General Don Wagoner and Chief of the Air Force MSC, or the Air Force equivalent to the MSCs. He lives in Houston now. A number of these young Air Force officers were tremendous. We also had a number of foreign students. Colonel Tompia was from Chile. Colonel Tisshenda later became The Surgeon General of the Thai Medical Service. We also had students from Japan and Korea. There was one dental officer from Pakistan. Major Conner was an MSC type from Canada. I think that's most of the foreign officers we had.

It was an interesting experience because, first of all, we had to be accepted by Baylor to be in the program. Instructors from Baylor came down to lecture to us. I can hear Dr. Kilgore on logic now. When he got through, none of us knew what logic was. Dr. Capps came down to teach communication. In addition, Army instructors who had gone through the program themselves taught some of the courses. [Lieutenant Colonel] Bernie Rappaport and [Lieutenant Colonel] Seth Lethicum taught. [Brigadier] General William Hamrick—he was Colonel Hamrick then—was the course director. He had gone through the program himself. Just about one class ahead of us, I think. Then he became the course director. We spent nine months at Fort Sam Houston taking courses to meet the requirements for the graduate school at Baylor. We also took courses in statistics and financial management.

There were courses that applied particularly to military life such as supply logistics. Our big project was to take the old MFSS [Medical Field Service School] quadrangle and convert it into a thousand-bed hospital.

MAJ Gurney: Oh my.

BG Dunlap: That was interesting. This is where the nurses really were in great demand because many of the MSCs really didn't know what went into a total hospital. They had their own specialty. So they fought to have a nurse on their committee to help in planning for converting it into a thousand-bed hospital. (Laughter)

We also had to meet the requirements of a thesis. This was an individual project. Students selected certain hospitals—civilian or military—to be the base for their project. Then they would coordinate with the administrators to find out what were the problems their hospital faced, problems they would like to have someone come in and study. It was a two-week study I think. One of the MSC officers, Colonel William Hastings—a senior MSC officer—and I went down to Corpus

Christi to Memorial Hospital. It was their equivalent to a county hospital. We had been cautioned that our subjects would be given to us when we left Fort Sam. When we got there we were not to let anybody, the administrator or anybody, change our study topic. They had a tendency to do that. So, sure enough, when we got down there, Colonel Hastings was to study the emergency room. As a senior MSC who'd been an executive officer of a hospital he really didn't know much about an emergency room. So, you know where "Lil" put in a lot of extra work to help sort it out.

I was supposed to evaluate some of their personnel problems. We got down there, however, and the administrator said that they had just had a visit from the Texas Commissioner of Health Office. They had just inspected them. Staphylococcal infections were really quite a problem at that time. They wanted me to evaluate their staphylococcal infections in their hospital. I said there was no way I could do their entire hospital in two weeks. So, I got in touch with Colonel Hamrick to get permission to change my area of study. But I would concentrate only on the obstetrical department. They did have a high incidence of staph infections in the obstetrical department. So I did my study in the obstetrical department.

This meant that we were on our own. We could spend as much time—set our own hours—as we wanted to on it. I had a ball because the large percentage of the patients were Hispanic. Their culture is quite different when it comes to illness than our culture is. When Mama is in to deliver, the whole family comes and sits in the waiting room. They bring all their food and their Big Red soda pops. It was quite an experience. Also, I was in there around the clock. I came in at all different times to observe the activities in the different areas. It was nothing for a person who was very cautious to change clothes to go into the delivery area or the labor area. Then on the three-to-eleven shift, when it became time for supper, they'd call out to the nearest taco restaurant and go out in that outfit to the taco restaurant to bring in food for everyone to eat back in that area. That way they didn't have to go down to the mess hall. So I just had a ball doing this study. At the end of the two weeks, we had to write up our study and turn it in. That was done in lieu of a thesis. But it was prepared at a thesis level.

Then, we had orals. The faculty from Baylor came down and we had a member of the Baylor faculty and of the MFSS faculty for our orals. We really were scared of that. We had done staff studies and our study project. We didn't fear those as much as we feared those orals. We didn't know what on earth they were going to throw at us. We sure didn't want Dr. Kilgore to be one of the faculty on our team. He wasn't on mine. Boone Powell, who was the administrator of Baylor University, was the Baylor faculty on my team.

If you passed orals and had maintained a B average, then you were eligible to go into the residency program. Now, at that time there were just a very few students who had been admitted to the program. These were senior people who had been admitted to the program but were not in the Baylor part of it. They weren't working toward the degree. They were senior people in the AMEDD and would be holding top positions the remainder of their careers. They did the projects but

they didn't have to have the orals. They also didn't receive a degree from Baylor University. Those of us who were in the degree program did a residency. This was always a subject of debate in the different schools of hospital administration. There was a move at that time to discontinue the residencies. But, thank goodness, the Army fought it. They still to this day have the residencies. In my opinion, that was one of the very best parts of the learning experience of the total program.

I think that pretty well covers MFSS. Any time you're in concentrated academic setting, as you are in the Army in every course you take, and having to meet the requirements from Baylor also, it was study, study, study. My family didn't see me. They knew I was in San Antonio, but they didn't see me very much during that period. It was a really good program.

BAYLOR RESIDENCY

MAJ Gurney: You did your second phase, or the residency portion, of your program at Fitzsimons Army Hospital in Aurora, Colorado.

BG Dunlap: When we were getting ready to leave, the chief of the Army Nurse Corps Assignment Branch came down to interview the nurses to see where they'd like to be assigned. They brought a team down from The Surgeon General's Office to interview the students to see where they'd like to do their residencies. The chief had me scheduled to go to Brooke to do my residency. I said, no way. I'd been stationed at Brooke. I know too much about Brooke. I wanted to go someplace other than Brooke to do the residency. It ended up to be a little battle to determine where I would go. Finally they let me go to Fitzsimons. There were two MSC officers scheduled to go to Fitzsimons. That would have put three out there doing their residencies. Even so, I got to go to Fitzsimons.

I was the first woman to go to Fitzsimons to do a residency in hospital administration. The residents were assigned to the executive officer, who was the preceptor. When I went to Fitzsimons the chief nurse wanted to be my preceptor. This generated quite a discussion. I said no. I wanted to be like the other two residents. I wanted to have the exec officer as my preceptor. The MFSS certainly backed up that desire. It isn't that I had anything against the chief nurse at all. But she was not a graduate of the program. She had her bachelor's degree. I had served with her before so I knew her. That had nothing to do with it. It was just that, being the first woman, I did not want to set a precedent that the nurse should be treated differently than the other two.

The exec officer, Colonel George Schunior, was my preceptor. Just a little note of interest: As we got into the program, I found that he was from the valley, my mother had been his first grade teacher. I told Mother about it. She pulled out some pictures and showed me a picture of the first grade class with little George Schunior there. (Laughter)

That's just a little sidelight to this.

MAJ Gurney: Interesting.

BG Dunlap: The residency at Fitzsimons was a tremendous learning experience for me. The way Colonel Schunior approached it, he told us he'd like us to identify the areas we wanted to spend time in, and how much time we wanted to spend in each area, based on what we considered our needs. Immediately I said I do not want to spend more than one month in nursing. I thought I knew nursing. That wasn't the purpose of my residency. Each of the three of us, with our preceptor's approval, set up our schedules. I had a ball going into the different areas. The one area I spent the most time in and learned the most in was logistics. That area was the most beneficial to my future career.

Life Expectancy Project

Lieutenant Colonel Nelson was the chief of Logistics. I really got to know all about maintenance and supplies and the issue that would be my project down in logistics. I was to come up with a five-year replacement plan for the equipment at Fitzsimons. I learned about the life expectancy of equipment and about the maintenance records for equipment. I really learned the equipment in that hospital. The reason this so impressed me was what happened after I turned in my report consisting of the five-year plan establishing priorities for replacement of equipment. At that time, at the end of the fiscal year, there could be year-end money available. The facility would have to quickly spend it. The commanding general was Brigadier General John Bohlander at that time. I'd been with him when he was the surgeon at Fourth Army. He got information that year-end money was coming down. They needed to quickly determine how they wanted to spend that money. I think we called them EPB [Equipment Priority Boards] boards at that time.

So they used my study to meet the priorities that had been determined. There were some changes made when the chiefs who sat the board massaged the list. For instance, they could convince them we needed this x-ray equipment more than we needed something else. But, basically, the study that I did was used to come up with the purchases that they were going to make.

I learned a lot about furniture. In one of my projects, they were going to refurbish the waiting areas. Well, I'm kind of short. One of my pet peeves is having to sit on couches and chairs where my feet don't touch the floor. (Laughter)

So, I said we're not purchasing any chairs that don't allow my feet to touch the floor. When we got ready to purchase chairs for the waiting room, we went down to the supply houses and I sat in all the chairs. That was our criterion. If my feet touched the floor, then we could buy that chair. (Laughter)

Of course it also had to fall within our budget. (Laughter)

MAJ Gurney: Did you write that into criteria in your study? (Laughter)

BG Dunlap: I think it was part of the "informal" criteria. (Laughter)

Truly, I was particularly concerned about the women sitting outside of the OB clinic. When we were down in the waiting areas, we could see there wasn't much space anyway. These women were sitting there trying to touch the floor but they

couldn't. Their feet would dangle, potentially cutting off the circulation at the back of their legs. That shouldn't be allowed. I can sympathize even though I've never been pregnant. That was why we were going to use that criteria for determining what chairs we were going to purchase for our waiting room areas. (Laughter)

Utilization of the Emergency Room

I also discovered some interesting things about how they used their emergency room. They had it set up to be handled by the outpatient clinic during the day. At night, it was a very limited emergency room. We found, though, that a number of the retirees came out to the post on bingo night, or to come to the movie. Then they stopped by the emergency room after those were over to have their annual physical or routine outpatient care.

MAJ Gurney: Oh, yes. (Laughter)

BG Dunlap: That would be when they came in for some condition that had existed quite awhile. It was convenient to come to the post and play bingo or go to the movie and then stop by the emergency room. Then our busy physicians (Officers of the Day) would have to come see them. They were covering the rest of the hospital.

At that time we still had TB patients at Fitzsimons, out in open wards. They did some studies, particularly, of the women TB patients. It was a challenge to fill all of that free, but boring, time for them. So many of them were mamas and they were used to leading a very active life and suddenly they were hospitalized. Lieutenant Colonel Gritsavage was the chief nurse there. Alice Gritsavage was very good about working with those patients. She got sewing machines so they could sew and do things that they liked to do. They could use their productive skills and not just go down for the usual recreation activities they offered.

Post Housing

One of my big projects was housing. At that time the nurses' quarters came under the chief nurse. They had many maids in the nurses' quarters—custodial people. Each month when it was time to pay quarters fees, the nurses came to the chief nurse's office. Major Mary Matlock was the education coordinator. She and the NCO would sit there and collect the fees for quarters. (Laughter)

Anything that came up with the maintenance of the nurses' quarters or assignment of the nurses came under the chief nurse.

They had a BOQ [bachelor officer quarters] for the male officers. That came under the officers' club. They also had two sets of family housing. That came under some other organization. Enlisted housing came under yet another one. So I studied all of the housing at Fitzsimons. As a result I found that there was one great big building that housed civilian women, mostly in food service, custodial personnel, and nursing assistants. I couldn't understand why we had civilians living on our post. That went back to years ago when the trolley line coming out to Fitzsimons ended way back in town. There was no other transportation for them

to get to the post. So they made provisions for them to live on the post. They were still living on the post all these years later. Likewise, down in what had been the stable area, they had quarters for the civilian men for the same reason. They were allowed to live on post. We had very crowded, unsatisfactory quarters for our enlisted personnel. So my recommendation was to discontinue housing civilians. Now, a bus came right in front of the hospital. The post discontinued housing civilians, and they converted those quarters into nicer quarters for our enlisted personnel, particularly our top NCOs. They could have semiprivate rooms.

For the officers, this was a little more difficult. I recommended that we have a central billeting officer. The chief nurse opposed this. She did not want to lose control of the nurses' quarters. This wasn't very pleasant for me because I was making a recommendation opposed by the chief nurse. But I was doing it in all honesty, based on how I felt it should be done. As a result, a central billeting office was established. Nurses' quarters, then, became a part of central billeting. The chief nurse got mad at me and didn't speak to me for about a month. But every Thursday I made my bagel run to the grocery store and bakery. Some people went with me on my bagel run every Thursday and the chief was one of them. So, after a month or so, she got over that and we made bagel runs together and became very good friends again.

New nurses' quarters were being built at Fitzsimons at that time. My project then became to work with the post engineer on the new quarters. We were in the process of accepting the quarters from the district engineer. Once that was done, I planned and coordinated the move from the old nurses' quarters to the new nurses' quarters. That could be carried out after getting the furniture and everything else for the quarters. That was quite an accomplishment—an operation. Especially since we had people working three shifts. I had to coordinate getting transportation to come over to pick up their things and move it over to the new quarters.

MAJ Gurney: Do the buildings that became the new quarters still exist at Fitzsimons?

BG Dunlap: To my knowledge they do.

MAJ Gurney: What are they now? The BOQs?

BG Dunlap: The nurses' quarters were set up in a quadrangle with a nice yard. They were two stories high. On either end there was a section where they intended to put the field grade officers. Each field grade officer would have a living room, a bedroom, a bath, and they shared a kitchen with another field grade officer. You'd have two field grade officers on each end of those quarters. The others had a living room, a kitchen, a bath, and two bedrooms. That was intended for the company grade officers. Colonel Gritsavage changed that around a little bit and got permission to occupy them. The senior field grade officers could have one of those two bedroom suites. Therefore I had my living room with a dining area at the end, a kitchen, two bedrooms, and a bath. I could use the one bedroom as a study.

Others occupied them as they were planned. It certainly made it much nicer for us. They were very nice quarters. Any time you move into new housing though, there's always a shakedown period. (Laughter)

The disposal didn't work. I was the project officer, so I'd get a phone call. "My disposal won't work." Or "I locked myself out of the storage area." In the basement we had storage areas and washing facilities down there. "The washing machine doesn't work." Even after I had completed that project they'd still call me when something was wrong.

MAJ Gurney: So, my understanding of your residency was that you rotated through each of the departments and spent the amount of time there that you decided you needed. You then did projects that required an extended period of time.

BG Dunlap: That was a requirement. You had to do a project in each area you went into. That project had to be submitted to MFSS and to Baylor. That was part of the academic requirement for these projects. It was problem solving, really. (Laughter)

MAJ Gurney: Sure.

Intensive Care Nursing Course

BG Dunlap: There are two other points about my experience of historical significance to the ANC. They were doing open-heart surgery at Fitzsimons. A nurse had been assigned there to do a study to determine if the Army Nurse Corps should have a course to prepare nurses to work in the open-heart surgery area—a cardiac nursing course, I think they were going to call it, or something like that. When I was in education and training I looked at that course, but my recommendation was no. We needed an intensive nursing course. We did not have an intensive nursing care course at that time. Open-heart surgery was only performed in perhaps two hospitals—two medical centers. I'm not sure about the number. My point was, if we prepared them, we'd have to assign them to that area, which meant that there were only two hospitals where they could be assigned. Otherwise, we were not utilizing them properly. I felt that our need was greater in intensive care. We should develop an intensive care nursing course.

MAJ Gurney: What made you think of intensive care? Up to this point we haven't encountered intensive care. The closest we've come to it is an acute care ward. Had you seen somewhere else the idea of intensive care nurses?

BG Dunlap: No. No. But, as you looked at the surgery that was being done, we had recovery—post-anesthesia. And then, using the progressive patient care concept, we kept the sickest patients longer in a certain area. I could see that the patients having open-heart surgery required intensive care. But they weren't the only ones who required intensive care. We needed nurses prepared to take care of

all of those requiring intensive care as opposed to just open-heart surgery. The nurse who was doing the study about cardiac nursing was a friend of mine, Lieutenant Colonel Ruth Greenfield. She was on my bagel run. Her study had been pretty well accepted by some of the people at Fitzsimons, particularly the heart surgeons. They felt this would be tremendous. I kind of threw a wrench into the whole idea. But I just couldn't agree that we in the Army Nurse Corps could justify conducting a course for nurses to work in just a few areas. I later replaced Colonel Greenfield at First Army headquarters as chief nurse.

MAJ Gurney: Did you write a report that expressed your opinion on this?

BG Dunlap: The Army Nurse Corps assigned Colonel Greenfield the project, so her report went directly there. Although I didn't have a direct line to the Army Nurse Corps Chief, the Corps was always interested in what the Baylor residents were doing. To my knowledge, I did not send them any copies. The chief nurse at the hospital knew what the residents were doing. We all rotated through nursing. We reported our projects to our commander.

MAJ Gurney: I have seen in my records some reference to the suggestion for a cardio-thoracic surgery course. This emphasis on cardio-thoracic surgery really is the root of critical care in the military. So that's why I'm curious.

BG Dunlap: This would have been from 1959 to 1960.

MAJ Gurney: You have no personal knowledge that your report suggesting a generalist, intensive-care course went anywhere other than the MFSS and Baylor?

BG Dunlap: That's right.

MAJ Gurney: You don't know then whether it was used in the consideration of their decision relating to developing a course?

BG Dunlap: They did not develop the cardiac nursing course.

MAJ Gurney: But did they develop another course?

BG Dunlap: Yes. [Major] Millie [Mildred] Fritz did that here in San Antonio at Brooke. She was one of the nurses working in the open-heart surgery area. She could probably give you some more on that.

MAJ Gurney: This was 1959 to 1960. A decision was made sometime thereafter. Do you know when that course may have started?

BG Dunlap: No. I don't know. When I finished my residency, I came back here to the MFSS to teach. I think it was in the mid '60s.

Nurse Methods Analysts

There was another area in which I was involved. [Major] Irene Miclick was a nurse methods analyst at Fitzsimons. She was one of the first, perhaps even the first. We had one of the first conferences of nurse methods analysts [NMA] out at Fitzsimons during the time I was doing my residency. [Lieutenant Colonel] Ollie Plunkett was the one who was in The Surgeon General's Office at the time. When I did my project in the comptroller's office, the NMA was assigned to the comptroller. This had always been a subject for discussion. Should the NMA be assigned over there? There was much debate about this in the beginning of our NMA program.

Mickey [Irene Micklick] was assigned to the comptroller's office. She now is retired and lives up in the Carlisle Barracks area. Mickey had such an analytical mind and was just ideal for that position. She also had a beautiful personality. She could go into the areas other than nursing, for example, to x-ray, to do her studies and come up with her recommendations. And she could do this in areas that were always difficult. I imagine it still is for nursing in the clinic area. The clinics usually consider themselves coming under the physicians. I'm talking about the orthopedic clinic, or ENT clinic, or others. They didn't want nursing to have anything to do with them. Mickey was able to go into these areas and observe the techniques and to make recommendations to attain and maintain the quality of care they needed. And she could do this without stimulating any hostilities. (Laughter)

I worked with Mickey during that period of time. I helped her set up the Conference of Nurse Methods Analysts. This is when I first became interested in the nurse methods analyst. It was beginning in the Army Nurse Corps. Having worked with her, I became very interested in the role of the nurse methods analyst in the hospital. When I was asked what I would like to do when I finished my residency, my first choice was to stay on at Fitzsimons as the nurse methods analyst because Mickey was going to be leaving. My second choice was to be an assistant chief nurse. Those were the two things that they had discussed with me.

The preceptor received a call one day from [Lieutenant Colonel] Jeanne Treacy who was in The Surgeon General's Office in personnel, saying that I was going to be assigned back to the Medical Field Service School to teach in the Department of Nursing Science. He called me in. I did not want to go to teach. I've never taught. I knew nothing about it. I did not want to go back there to teach. I wanted to either be an NMA or an assistant chief nurse. I went back to the Medical Field Service School to teach. (Laughter)

MAJ Gurney: You obviously won that battle. (Laughter)

BG Dunlap: But I'll go into that next. To finish up Fitzsimons and the residency program, I did go into nursing service and was able to spend a month there. I think it was good to help me observe some of the personnel issues. My time in personnel and logistics and supply helped me to be able to identify some of the problems that nursing was having. I was able to see their problems in getting supplies

and where the bottleneck was. So often it's just a lack of communication. I worked in the Registrar's Office. In the Registrar's Office I was interested particularly in our ambulance service. I worked toward equipping our ambulances with emergency equipment, which was very lacking at that time. Then we established systems for them to check on each shift to be sure that the ambulances had the equipment that they should have before they went out on runs. Runs were being made without adequate equipment to do anything if they got there and found some of the resuscitative equipment wasn't functioning or wasn't available.

I visited food service. That's always interesting because that's one that's so closely related to nursing. As I observe food service today in our hospitals, some of the problems that existed then still exist. Who serves trays? We did get away from cooking the meals on the wards. Food service does the cooking and sends the food up. But, at least then, it was still the responsibility of nursing service to get the trays out to the patients and to pick up the trays when the patients were finished. This while we still had maybe just one nurse and a corpsman on duty covering a ward. To me, that is not a nursing service responsibility. But there are some battles that go on and on.

Collocating the Section Chief and the Department Chief

I also spent time in professional services. At that time, as part of some of the management studies, there was a concept that instead of the medical supervisor and the surgical supervisor physically located in the office of the chief nurse, they should be located in the suite of the service chief. So, the medical supervisor's office would be down with the chief of the Department of Medicine. And the NCO for medical service would be in her office. They would be there so that the supervisor and the chief of the department could work very closely. She would still report to the chief nurse and come under the chief nurse for command and control. It was just that they were physically located in the section. That was to encourage closer cooperation and planning between the nursing supervisor and the chief of the department.

MAJ Gurney: How did the chief of the Department of Nursing feel about that?

BG Dunlap: It worked at Fitzsimons. People make things work. Lieutenant Colonel Winifred Mata was the nurse supervisor. Colonel Gritsavage was the chief nurse. They worked together nicely. But if we had a chief of the Department of Medicine who demanded her attention all the time and didn't recognize she belonged to nursing service, it might not work. The system had its merits.

MAJ Gurney: Were there any problems with that system?

BG Dunlap: People. As some people changed, then there might be trouble, just what I'm talking about. And there could be problems with the nurses, too. Did the nurse then become so identified with the department and the physician as opposed to the chief nurse that it could disrupt order in the Department of

Nursing? But it had its merits. You can't use Brooke as an example because it's not typical of any hospital. There we have medicine and medical nursing in the main hospital and everywhere else. But, take another hospital, how closely does the medical nursing supervisor work with the chief of the Department of Medicine? They don't always work as close. This really did help. If you were having problems in the medical service with the physicians, the ward officers, orders, coverage, anything like that, the medical supervisor would report each morning to the chief of the Department of Medicine. They would discuss these problems. The department chief could come to understand why nursing coverage was as it was. The total hospital only had so many nurses to cover the total hospital. That's why on medical service you only had so many nurses. They'd avoid having him think they don't have their share, or surgery's got them all. It had its merits in that particular setting. But people make things work. People can be jealous about their territories. We all have our territoriality.

Male Nurses

MAJ Gurney: During this period of time at Fitzsimons, did any male nurses come to work at Fitzsimons?

BG Dunlap: We had some male nurses come to work at Fitzsimons. That was my first experience working with them. Of course, mine was in a limited relationship because I didn't work on the ward with them. But I gained experience during meetings with them and by observing them. Colonel Gritsavage was a real supporter of the role of the male nurse. As you know, when the male nurses first came to work, they thought of them in terms of being on the GU ward and in psychiatry and orthopedics. Those were the only wards that they felt the male nurses could be assigned to. And they did work in those areas. We had the TB wards at Fitzsimons, and they did have some of the male nurses working out in the male TB wards also. Ultimately, the male nurses worked in a more limited range of areas. They were placed in psychiatry, orthopedics, some in the OR and anesthesia, male GU and TB wards. This is how they were placed in most of the other hospitals.

MAJ Gurney: How did the men feel about this? What did they say?

BG Dunlap: Actually, those were some of the desirable areas to work rather than having to work in some of the other areas.

MAJ Gurney: Female medical?

BG Dunlap: (Laughter) I didn't feel that they resented this. They were happy to be able to be commissioned officers and to be a part of the Army Nurse Corps at that point.

MAJ Gurney: How did the women feel about the men coming in?

BG Dunlap: There were some who had questions about the men. But at Fitzsimons, I didn't experience that. We had some real fine male nurses out there. They were accepted. The first place that I encountered some opposition to the male nurses was when I was chief nurse in Okinawa. I had a number of male nurses in Okinawa. I had assigned one to the pediatric ward. My supervisor came down, Lieutenant Colonel Sally Stallard, and said "We have a problem." What is it? "The chief of Pediatrics says he wants no male nurses on his service." Why? "He's afraid that those male nurses would harm his little girl patients." He had to be cautious and not let anything happen to those "little girls." My position was that when children are admitted to a hospital the female nurse takes on the mama role to the youngster, whether it is male or female. We become mamas, and they relate to us as a substitute mama during their hospitalization. Well, they have fathers at home also. Couldn't the male nurse take on the role of the father image to them while they're in the hospital? They wouldn't miss their daddies—that relationship—as much. So we had a discussion with the chief of Pediatrics and our difference of opinion was taken to the commanding officer. Fortunately, the commanding officer supported me so I was able to utilize the male nurses on the pediatric wards. Most of my male nurses were married and had children of their own.

MAJ Gurney: Were there any strategies that you used in order to win over the chief of Pediatrics or others who opposed male nurses?

BG Dunlap: This was the only time I had a face-to-face encounter about the utilization of male nurses. I believe you select people for assignment whether it's male or female. You have to consider the individuals who you are assigning.

MAJ Gurney: Back at Fitzsimons, were there any other things that you wanted to wrap up related to your residency?

BG Dunlap: I actually went into more than I had on my notes. I'd think of the different areas where I did studies. I studied in the psychiatric section. I'm not a psychiatric nurse. I may be psychiatric. But I'm not a psychiatric nurse. (Laughter)

I spent some time there really learning what they were doing and the treatments they used. I saw the electric shock treatment that they were doing there. It was the first time I'd ever seen that. I saw them use insulin shock. We were still using that procedure at the time. I had never seen that before in the hospital. I think those are the primary areas there in connection with the residency.

I think you can see as I got on into different positions and assignments, then later as Chief of the Corps, the importance I placed on the role of the nurse methods analyst and the graduates of the hospital administration course. I placed great importance on graduates going into NMA positions for at least two years. I felt with that background, that was the best chief nurse preparation they could have because with that experience they learned what makes a hospital work or not work. A chief nurse has to know that. She can't just know nursing service. No matter

how qualified she is in nursing, she can't be an effective chief nurse if she doesn't know the hospital and what makes it work and not work.

MAJ Gurney: What was happening in the Army Nurse Corps during this period?

The Personnel Coordinator and Administrative Assistant

BG Dunlap: Who knows? We hardly saw the Army Nurse Corps. I don't recall any specific areas of change or transition within the Corps. The role of the nurse methods analyst was being developed. We also had a role referred to as a personnel coordinator. That person was assigned to the Chief Nurse's Office. She was responsible for the coordination of enlisted personnel. I think Peg Hughes—Lieutenant Colonel Margaret Hughes, who's out in the Madigan area—was a personnel coordinator. She was down here at Brooke. This went back to having enlisted personnel assigned to nursing service and the coordination of their assignments and so forth.

MAJ Gurney: You didn't have a chief wardmaster to do those duties for the enlisted?

BG Dunlap: For the enlisted we had the chief wardmaster. But we also had to think about education and training of the enlisted personnel as well as the officer personnel in nursing service. This wasn't the educational coordinator. We had an educational coordinator. This person concentrated on personnel.

MAJ Gurney: So, she handled all sorts of personnel actions?

BG Dunlap: She was the coordinator. The chief nurse had the responsibility. She served to help the chief nurse in the personnel arena.

I'm trying to think now of the assignment of an ANC in the Office of the Chief Nurse as an administrative assistant. If you remember, the Department of Medicine had an MSC officer as an administrative assistant. Each of the departments had an MSC officer as an administrative assistant. So, why not the chief nurse? Then, it became someone's bright idea "Why not assign WAC officers as the administrative assistant to the chief nurse?" I think that was tried at some stations. But it didn't work out. I know when I was chief nurse at Walter Reed, I had an MSC assigned as my administrative assistant in the office.

MAJ Gurney: Can you pin a time when this appeared? The MSC as administrative assistant?

BG Dunlap: I think it was during the period of time I was at Fitzsimons, '59, '60, '61. When the DACOWITS Committee was formed, there was a directive put out by the Secretary of Defense, George Marshall, and Assistant Secretary of Defense Anna Rosenberg. This was as a result of some of the studies. A letter was put out that was used in the Army Nurse Corps to justify getting the administrative duties

done by other than nursing personnel. I know we used to pull that out every time and wave it in their faces to justify it.

MAJ Gurney: That was a Secretary of Defense letter?

BG Dunlap: The whole emphasis was better utilization of professional personnel. We were trying to recruit people. In the process we were looking into how our professional people were utilized doing many nonprofessional duties. So, it would have been in that context. You may remember, the Valley Forge studies were done in '49 and '50. We had [Lieutenant Colonel] Daisy McCommons, [First Lieutenant] Eileen McCarthy, and [Captain] Robena Anderson involved in those studies. It was during that period when they came up with the idea of progressive patient care. We were also looking at the concept of unit managers.

MAJ Gurney: History taught us the importance of quick and massive mobilization. It was after Korea, though, that we determined one of the factors that would aid mobilization was to take nonnursing duties away from nurses. That was being discussed in the early to mid '50s.

BG Dunlap: That would be when DACOWITS was organized.

Medical Field Service School

BG Dunlap: By 1960 I had eighteen years of service and held the rank of major. I had never done any formal teaching, didn't know what a lesson plan was, and there I was thrown into the Medical Field Service School. At the time that I reported in they were undergoing a change in staffing. [Lieutenant Colonel] Peg Carbaugh Jones was leaving as the director. [Lieutenant Colonel] Edith Shutt was leaving the deputy director position. Lieutenant Colonel Eileen Fitzgerald was coming in as the director. Lieutenant Colonel Regena Bennett was arriving to take the role of deputy director. After I reported in, of course, we all had to go through the "charm" school, Instructor Training Unit they called it there—ITU. I passed and was assigned to the Division of Nursing.

TEACHING DUTIES

I was told that I would be working with the basics [Officer Basic Course]. "So don't worry, you're going to be working with the Basics." [Major] Lucille Fisher was in charge of the basic group then. She was a delight to work with. For my orientation to the basic course, I sat in classes with them. That relieved some of my apprehension. I found out what was being taught in the basic courses was material I knew. It would be a matter of writing lesson plans and learning how to teach it. But, before too long, I was told instead I was going to teach the nursing research course.

MAJ Gurney: Oh, my!

BG Dunlap: Yes. Oh, my! That's enough to give anyone ulcers. I never did have them [ulcers]. But I'm sure I could have. What did I know about nursing research? And particularly since my master's was in hospital administration. So I began studying and trying to develop some lesson plans for nursing research. Before I got too far into that I was told there were going to be some changes made. Instead I'd be teaching nursing service administration and supervision, which is 168 hours of instruction.

MAJ Gurney: First of all, did a nursing research course already exist?

BG Dunlap: No.

MAJ Gurney: So both of these were new courses?

BG Dunlap: No, no, no. The nursing service administration and supervision was being taught already. That was the hub. Now, remember the Army Nurse Corps Career Course students were separate. We had an AMEDD Career Course. Usually it had maybe three nurses in it. They were identified as people who would probably be moving up into top positions. Ruby Bryant went to it. Polly Kirby and people like that went to it. Nursing administration and supervision was the hub of the ANC Career Course. I was told I was going to be teaching that. So, I had to switch gears again. (Laughter)

And I'm in one of those situations again. The deputy director was told she would then be teaching a nursing research course. I would teach nursing service administration and supervision. After she had gone through one class, it was decided that she wouldn't teach that any more. She had been a chief nurse in Puerto Rico. She certainly had much more experience than I had. My only chief nurse experience had been at Fort Chaffee, and that was limited. Even so, I was going to be teaching it. I learned along with the students. How do you compute nursing staffing for nursing care hours and things like that? Well, I learned it all before I had to teach it to the students.

MAJ Gurney: You kept one step ahead of them.

BG Dunlap: That's right. That first go-around was rough, rough, rough. But I survived, and the students did too. After one year it was decided the deputy director was going to be moved to BAMC [Brooke Army Medical Center], to the hospital. I would become deputy director. So, I became the deputy director of the Nursing Science Division.

MAJ Gurney: One year after you joined the faculty.

BG Dunlap: I became Eileen Fitzgerald's deputy. Of course, that makes you the course director and counselor for the students in the ANC Career Course. I was also made the counselor for the students in the AMEDD Career Course. My

teaching responsibilities were the nursing service administration and supervision course. It developed over the years. I was there for five years.

Remember? I didn't want to go teach! It was one of the best assignments I ever had. (Laughter) After I got into it.

My teaching responsibilities expanded. In the AMEDD Career Course they got some nursing hours, maybe two or three hours. I don't remember how many. The director taught some of them. But it soon became my responsibility to teach those hours. In hospital administration we had some nursing hours. It soon became my responsibility to teach the nursing hours in hospital administration. In the basic nursing course we always had a few hours that the director or the deputy director taught. I didn't write them all down. They had the NCO course there, and I'd teach the nursing hours. The patient administration or registrar course—I would teach in that. The supply course—I'd teach the nursing hours. When we had short courses, I'd be teaching the nursing hours in those.

So that I found I was doing an awful lot of teaching, and loving every minute of it

MAJ Gurney: Did anybody else work there? Did you take on those additional hours because you were enjoying teaching that much? Or because it was—

BG Dunlap: I was assigned. (Laughter)

Then Colonel Fitzgerald retired in 1963. It was May '63, or early '64. I became the director then, but I continued my teaching—not nursing service administration. Yes, I did, too. I still taught that block too.

MAJ Gurney: How did you manage that course in addition to everything else? Was somebody else doing the administrative management of the course?

BG Dunlap: Of that course? Such as—

MAJ Gurney: Scheduling of hours, keeping the students busy, or—

BG Dunlap: We had a nurse assigned to work with the Department of Operations—it was Operations and Training. They would take care of our schedule. We had to put the schedule up at the beginning of each course. So we had a nurse work on the ANC Career Course and one on the Basic Course. They would work over there setting up the schedule at the beginning of the course.

This is interesting; you talk about POIs—Programs of Instruction. We used to joke. There's always a program of instruction that's outdated. There's one that you're teaching from. And there's one that's approved. Then you have still another one that you actually are using as you're preparing to update it. They clamped down on us, saying we had to have written lesson plans for every hour of instruction. Prior to that, they were supposed to, but they didn't. So we really had to work on developing our lesson plans and having them approved along the way. But I kept nursing service administration. I taught that section the whole time I was

there. As a result, in my later assignments, I knew the members of the Army Nurse Corps.

MAJ Gurney: You sure did.

BG Dunlap: Because they all came through Basic. I had some contact with them. Then, I taught them in the Career Course. General Slewitzke was one of my students—one of the good students. (Laughter)

Also, I taught in the hospital admin course. I was the first Army Nurse to be made an assistant professor of hospital administration at Baylor. The faculty teaching in the hospital admin course who were qualified were made assistant professors upon recommendation of the course director and the commandant. Until then, nurses hadn't done that. [Colonel] Sam Edwards was course director at the time. He said he wanted to nominate me for that. So, I became an assistant professor of hospital administration at Baylor.

MAJ Gurney: When you were teaching and interacting with that massive number of nurses going through the schoolhouse, could you look out in your class and say, this person's going to be Chief of the Corps, or that one's going to be a leader? Could you say that at that stage in their careers?

BG Dunlap: Yes.

MAJ Gurney: How did you know that?

BG Dunlap: Absolutely. I think any teacher can—working with the students as long as we did in a course like that, we could identify those who we thought certainly had potential for leadership.

By the same token, there are those who they think, boy, they have reached it. (Laughter) Really, they're struggling. I can give you names. (Laughter)

Bless them. They were struggling to get through this course. We spent hours and hours counseling. One particular student who I spent hours and hours counseling struggled so. I would practically tell her what the exam questions were going to be the next day, but in a different format. And she still couldn't pass the exam the next day. We really worked with them like that. I think that's one of the satisfactions one receives in teaching. You can certainly see those you identify with potential realize that potential. Equally rewarding was the occasional surprise when those whose potential you questioned exceed your expectations when they got out of the academic setting and into the clinical area. I've seen that.

THE ARMY NURSE CORPS MEDAL

We started the ANC Medal during the time I was down there. The first student to receive the ANC Medal was [Captain] Angela Hennick. [Captain] John

Girvin, who's now the assistant chief nurse here at Health Services Command, was the first male nurse to receive the ANC Medal.

MAJ Gurney: What did you recognize in those students? How did they stand out to you?

BG Dunlap: They were not only good students, but they demonstrated those leadership qualities that you see in the way they worked with their classmates. Their classmates respected them. You know how much group work they do in the course. I guess they still do it at the academy.

MAJ Gurney: I'm sure they do.

BG Dunlap: Most military schools do all kinds of group work. The students would kind of look to them to be the group leader. They volunteered for a lot of those things. But the students looked to them. Those were the things that we looked for in the criteria that were established for picking the ANC Medal winner. Naturally, this person did not necessarily have the top academic record. But they had to have one of the top academic records plus have these other characteristics. We even established it so we had their peers rating them, too. They would indicate their first, second, and third choice. Members of the nursing faculty who had contact with the students and taught in the program did the ratings. It would always come down to: "Oh, she's smart. She's got the top grades. But you know, she really doesn't get along." Or, "Her classmates don't look to her." Something like that would come up as you'd get down to the process of selecting this person. You can spot them. I can.

Students are surprised as I meet them now. They're all retirees. I can say, "Well, I remember you. You were in the Class of '61. I can see you sitting back there next to so-and-so." They always seated students alphabetically. So, midway in the course I'd switch it and have the As and Bs and all move into the back and the X, Y, Zs and all move up to the front.

MAJ Gurney: Certain students had traits of informal leadership?

BG Dunlap: Their classmates respected them. The faculty could say, "Well, look in my class. Any time a question comes up, you can depend on so-and-so to be able to come up with a logical answer." They could work through the problems and lead the groups they were in.

We took all the students out to [Camp] Bullis for a week. We could really see leadership out there. Those who could take all of the bumps and knocks and what-not in the field turned out to be the leaders. They'd enjoy it. They made the best of it. Those folks could make it a learning experience and not complain about what was going on all the time. We could see it in the students. You've seen it, I'm sure, in your class. Immediately there are certain ones who want to be the leader. They try to impose their leadership on their classmates. We could see the resistance of their

classmates. They don't want that person as their leader. They want someone else. You've seen it. Leaders emerge rather than are chosen or appointed. If we appointed someone to be the chairman of a particular group, as we sat around observing how they operated—it would become evident that they might not be the leader. We tried to put them all in the leadership role. We wanted to expose them all to it. Then we could evaluate how they handled it. We could see who was supporting the individual who was struggling in the leadership role. So, who was the real leader? It was the one who was doing the supporting. They worked to help that classmate pass.

MAJ Gurney: Good leaders are good followers.

THE CHALLENGES OF TEACHING

Let me ask you another question. During your time at MFSS, was there anyone who you really depended on to help guide you through? At first you were pretty green in this outing.

BG Dunlap: What do you mean “pretty” green? I was Irish green as an instructor!

MAJ Gurney: Who did you use as a mentor at this point to help you get through this difficult time?

BG Dunlap: I don't think I can single out any one individual. [Major] Lou Fisher was a big support here. I couldn't go to the deputy. I didn't value her judgment. [Major] Dru Poole was on the faculty then. But I didn't really go to her. There were a lot of new people on the faculty at the time. There were some, who like Dru, had teaching experience. I sat in on a lot of the classes and observed techniques of many of the instructors. So, I struggled through it. It became easier. I began to develop my teaching techniques. We came to know whether we were keeping the students awake or not. (Laughter)

The biggest frustration is test preparation. How are we going to evaluate the students? We could think that we had written a test that covered what we've taught that they should know. There's no question in our minds that they should know it. It could be such a disappointment to find that either we didn't teach that or our test wasn't prepared properly.

MAJ Gurney: It didn't measure what you taught?

BG Dunlap: Or it wasn't prepared properly—that's right.

MAJ Gurney: Did you end up giving some tests that had those problems? Or that were problems because they didn't measure what was taught?

BG Dunlap: I'm sure I did. I know you expect all your students to make good grades. But there'd be certain areas, certain questions that you couldn't understand

particularly well when you've covered staffing issues. A big challenge is when you have OR nurses and nurse anesthetists who were not out in the nursing service, per se. They're restricted in their own small clinical areas. Or, Army Community Health nurses who were not involved in staffing day by day. I'm not saying they're not involved in staffing. But they're not involved in total nursing service. They'd say, why do I need this? I'm an OR nurse. That was a challenge for us.

MAJ Gurney: Did you have students challenge you on tests? Or content? How did you deal with the challenge from the students?

BG Dunlap: I tried to point out to them how this material was important. I used this when I was in assignments too. I would assign only people to MFSS who have been there, who have had the experience, and who could speak from experience. You have had instructors who have had theory only. They teach from the book. They can't relate it to practical experience. Students don't learn as much from them as they would from a teacher who has had the experience. This was what I tried to do. I tried to share my own experiences with them as they related to some of these things. I'd work my lesson plans around that.

I got into those situations, for instance with operating room nurses who couldn't relate to the content. I'd say, "Look. You're a lieutenant colonel. You're a senior nurse" or "When you're a major, you're a senior nurse. You might have to represent the chief nurse some time as the senior nurse. How would you do this or that?" It was a challenge, but I loved it. I really did. I got to know all of these people. Later, as I moved in as chief of assignments, I knew them. Then I could see what they had done after they left school. I could determine if their potential as a student had continued to be developed as they moved into different assignments. "Hey, that's someone who can be a chief nurse, or an assistant chief nurse. Put them in that chief nurse position." I can think of one officer. She'd say, "Oh, don't do it. I'm not ready for that position." I'd say, "Go." (Laughter)

THE ARMY NURSE CORPS MANUAL

Okay. Now, I've got to get back on my subject. I mentioned, at one time, the nursing manual—The Army Nurse Corps Manual. We wanted a manual for the Army Nurse Corps nursing service so that the chief nurse would have this manual to work with. It would have our AR 40-6 *Duties and Responsibilities*, in it. They took something of everything we were teaching—human relations, staffing, uniforms, what I was teaching in my nursing service administration and supervision course. It took hours out of that course. It became a reference manual for the chief nurse. She could use it in any teaching or counseling that she might want to do. It was her guide.

I can see it now. [Major] Polly Maxwell spent hours and hours and hours on that. Then, when she moved on, [Major] Marge Lindau finished it up and got it out. I wonder who else might have one? I'll bet Ski Straley knows. She was there with me. I had one.

We also worked with the Extension Division at the MFSS. They had their own writers there. They came up and worked with us in preparing the extension courses that were to be sent out to the reserve units. They used our lesson plans in developing those courses.

FIELD NURSING MANUAL

A big part of the Medical Field Service School was field nursing. We developed a Field Nursing Manual also. It was not of the quality as this other one, but [Major] Edna Stepenbach and [Major] Peg Maher worked on that. They were on the faculty at MFSS and teaching the field nursing aspects.

A big part of the field nursing experience was to take the students out into the field, set up the hospital, and have simulated casualties come through. We were out there for a week. We felt that this was certainly giving them a good orientation to what they might find in the field. We participated in testing field uniforms and different uniform items, but particularly field uniforms. I can remember when we had them out in the field. Some of the faculty were in the test field uniforms. [Major] Betty Clarke was down here for that, too.

MAJ Gurney: That wasn't part of Operation LONGHORN, was it?

BG Dunlap: Oh no, that went on back in the '50s at Fort Hood. Colonel Short participated in that. She'd go up there. She took Sister Charles Marie up to see it, too. Colonel Short can tell you stories about Operation LONGHORN!

EXERCISE BLOWUP

One of the big things during '60 to '65 was the mass casualty and nuclear medicine courses. That's when we had Exercise BLOWUP. We took the students out to [Camp] Bullis and they simulated a big atomic explosion. The cloud went up. And all the casualties were out and around. This was quite popular. Many civilian groups were brought in to observe this. Dr. Blocker, who was dean of the Medical School at the University of Texas in Galveston, was a reserve general officer. He brought the medical students from Galveston up here for that. He also brought all kinds of civilian groups in to observe this. We participated in it as faculty and students. We set up the hospitals, then worked with the students treating casualties and preparing them for evacuation. We also looked at evacuating casualties to civilian institutions and how we would do that.

Some of them took the learning from this exercise—the treatment of mass casualties and nuclear disasters—and included that into their programs. Incarnate Word included some of it. The NLN was encouraging schools' faculties to learn more about mass disaster. Incarnate Word sent their faculty over here. Dru Poole was one who'd gone to the University of Minnesota. She taught mass casualty disaster up there well before they did that down here.

MAJ Gurney: That was the '50s?

BG Dunlap: I'm trying to think of who else was involved. Grace Davidson. There were three nurses who were involved in taking training to the universities. Dru was one of them.

I think that pretty well covers Medical Field Service School except just a couple of little things that make history interesting. (Laughter)

The first space shot took place while I was teaching there. Alan Shepard went up into space. There was no way I was going to miss that. I remember a nursing crisis up on the third floor. There were no elevators. So, I brought my TV in and lugged it up the stairs. Little portables weren't so little in those days. I put it in the back of the classroom, turned it toward me without sound so I could see what was going on as I was up there teaching. When it came time for the countdown to actually take place, I gave the class a break because I felt this was certainly of historic significance. I related it to whatever the subject was that day. (Laughter)

We all gathered around the TV and watched the first space shot.

MAJ Gurney: How neat.

BG Dunlap: For me, standing up on the platform there and watching the students react to it—you know how tense you'd get for every one of those space shots. We could feel it. It was quiet. Everybody was just so tense. Then, as it went up, we could just see and feel the relief and the joy. Then we went back to class. (Laughter)

The break was over.

THANKSGIVING AT THE MFSS

One of the things we did was celebrate the last Thanksgiving that I was there. That would have been the Thanksgiving of '64. I thought, "We really don't do anything about Thanksgiving. We just have the holiday and take off, scattering in all directions. We have students here away from home." Some of them in the Career Course had been away for a long time. We had all those Basics here—sometimes the first time they'd been away from home at Thanksgiving.

What's the meaning of Thanksgiving? Remember, now, we had the quadrangle down there at MFSS, and before class every day the Basics got in formation and they marched to class. During the breaks, we'd have our own band down there playing the Army Nurse Corps song. The Army medics and all those things were in that area. So, we had a real spirit down there at the time. We had parades in the quadrangle every month, including retirement parades and parades for other occasions. So there was a real spirit down there.

One of the things I wanted to do was to have a Thanksgiving breakfast the last day of class before they broke to go home for Thanksgiving. I think some of the faculty thought I had rocks in my head. But I suggested we could have it over at the "pit" [a student officers' club]. We could have it at 6:30 in the morning. [Major] General James T. McGibony was the commandant of the school. We also had a chaplain. Colonel Newell was the chief nurse of BAMC. We had her down with us. We also invited any of the nursing staff who wanted to come from MFSS,

plus the students in the Career Course and the Basics came down. We had it set up with a cafeteria line. They went through to get their food and be seated.

MAJ Gurney: You wanted some music and some singing?

BG Dunlap: I wanted some Thanksgiving music, and I wanted the students to do the singing. By this time, [Major Catherine] Kitty Betz was the course director for the Basic Program. I wanted to see if she couldn't find some of the Basic students who could sing. [Second Lieutenant] Mary Kuntz was one of the Basics. I've got a picture of her standing there singing with the group. (Laughter)

I wanted the song "We Gather Together to Ask the Lord's Blessing." That's a Thanksgiving song. I said that had to be a part of it. So, we set it up. I've got pictures to prove what happened. [Major] Alice Bender was my deputy at that time. She was very artistic. She did artwork and made Thanksgiving posters to put behind the head table. We wondered how many we would have show up. The place was filled down there that morning.

MAJ Gurney: Whoa!

BG Dunlap: It was filled—over 150-plus persons came down there. Then, after that was over, the students got in their formation and they marched to class. That experience had such meaning to me. Especially to have that kind of a response to it.

I don't think students were scared of me. I think they really wanted to do it. After I left, then, they told me the next year they did the same thing. But then, whoever took over after that discontinued it. They didn't do it again. But that was important to me because I really wanted the Basics to know that we in the military are not what some people had painted us to be. We are whole people. When we talk about body, mind, and spirit in nursing, we talk about it in the military, too. I wanted them to have that feeling, particularly at Thanksgiving time. I felt that we in the military could portray that to them. So, we did it.

MAJ Gurney: That's fantastic!

BG Dunlap: I got orders to go to Okinawa. I was ready to go—not to Okinawa. (Laughter) But, after five years, I was ready for reassignment. I was promoted to lieutenant colonel while I was at MFSS. I do not know if this is true or not, but I was told that the zone of consideration when I was selected for lieutenant colonel was close to 600 people. I was one of thirteen selected.

MAJ Gurney: Oh, my gosh!

BG Dunlap: I know there were thirteen selected. That's what I was told. But I don't know how large that zone was. I was ready for a change, to move on to something else.

INVOLVEMENT IN PROFESSIONAL ORGANIZATIONS

While I was teaching at MFSS, I had an opportunity to interact with the civilian community a great deal. Being a Texas nurse and belonging to District 8, I held office in District 8 Nurses Association. I also became real active in Texas Nurses Association. Colonel Short and I had really worked with them when I was on recruiting. I was very active in Texas League of Nursing also. Our Texas League conducted workshops in leadership, nursing service administration, and evaluation throughout the state on weekends. I was invited to be a member of the faculty and to travel with them on weekends to help put on these workshops throughout the state. Inez Haynes by then had retired and was the executive director of the National League for Nursing. As a result of my work with the Texas League of Nursing, Inez Haynes then saw to it that I was invited to belong to a National League for Nursing committee. This was when the "Blueprint for Action" was being developed. We developed the criteria for evaluating nursing service administration. So I served on that national committee.

MAJ Gurney: That's wonderful!

BG Dunlap: I would fly up to New York. And work, work, work—I mean we'd bring sandwiches in at lunchtime and work with some of nursing's national leaders as these professional guidelines were being developed. Then they conducted workshops throughout the country on the implementation of the criteria for evaluating nursing service administration. Later, I was asked to be resource person for them and I continued to work with them.

That led then into the Joint Commission for Accreditation of Hospitals. They were revising the criteria for evaluating nursing service. They set up a committee at their headquarters in Chicago. I was asked to serve as a member of that committee to participate in developing the criteria for evaluating nursing services. That's when Dr. Kenneth Babcock was heading the Joint Commission. So in addition to my duties here, I really had an opportunity to work with many of our fine nursing leaders throughout the country in the development of some of these things.

MAJ Gurney: How did the administration at the Medical Field Service School and the ANC tolerate your involvement in these kinds of activities?

BG Dunlap: They were happy for me to be an Army Nurse representative in areas that they hadn't been before. I would do my regular duties. I didn't have anyone teaching for me, or anything like that. I'd work it around the schedule at the school. A lot of things were on weekends. I'd fly to New York for weekend meetings. These were busy people in their civilian life, too. So we might meet on Thursday, Friday, or something like that. Or we might meet on Friday and Saturday and come home Sunday. But going back to my comment about the people who I met early in my career and how they influenced it. Inez Haynes was a former ANC Chief who became the executive director of the NLN. She identi-

fied me as someone who might be able to work on some of these committees. And she gave me the opportunity to do so.

The last thing in connection with MFSS: When I received orders to go to Okinawa, I said I really didn't want to go to Okinawa. I had been to the Pacific in World War II. I'd had a tour in Germany. The Pacific was not my favorite part of the world. I didn't mind going overseas again but I'd really prefer not to go there. General McGibony was the commandant. He had been the commanding general in Okinawa. He assured me that Okinawa was the garden spot of the Pacific. It was beautiful. I could spend time playing golf and traveling and having a great time. He pulled out pictures of the new hospital that he had helped design. "By all means, Lil, go to Okinawa and have a good time. After five years here you'll have a good time." I went to Okinawa.

MAJ Gurney: What year was that then?

BG Dunlap: 1965. But just prior to my change of station, Sam Edwards, who headed up the Hospital Administration Program, had nominated me and encouraged me to apply as a nominee for the American College for Hospital Administrators. We hadn't had an Army Nurse do this before. So I was nominated. Induction as a nominee into the college was to take place in San Francisco just about the time that I was going to be going on my way to Okinawa. So, I was able to be inducted and then go on to Okinawa. I did not pursue going beyond nominee status. I didn't become a member or a Fellow because as my career developed immediately after that, I wasn't going to be back into the hospital administration area per se. But at least I was nominated. I could stay in that status three years before I had to move on up to membership. But I dropped out.

MAJ Gurney: Were you aware at this time, as you were getting prepared to go to Okinawa, of any movement of American military into Vietnam?

BG Dunlap: Yes.

MAJ Gurney: Tell me about it.

BG Dunlap: I didn't think of it as going to a war zone. No.

MAJ Gurney: What did you think about the activities over there? What did you know about them?

BG Dunlap: I knew that the French weren't down there anymore, and that we were. I was really not thinking in terms of going into a combat zone as it was over there.

As I move away from MFSS, there's so much still that was involved in those five years that I can't put it all down now. But I'll try to keep thinking of it. As some of the things come up—

MAJ Gurney: We can always go back

BG Dunlap: I'll jot things down because this was quite an important era in the Army Nurse Corps during that period of time.

MAJ Gurney: We haven't really addressed what was happening in the global Army Nurse Corps at this time. You certainly were in the center of implementation of many of its programs. You were in a position to have special insight into these things.

For instance: what uniforms were you testing at that time?

BG Dunlap: We tested the green and white-striped cord uniform.

MAJ Gurney: What uniform were you wearing at that time?

BG Dunlap: The Hattie Carnegie was on its way out. We called it the "nursing mother" uniform. It had two high side pockets. What did we wear after that? Oh, we had the tans—a tropical worsted wool uniform. It was a skirt and blouse very similar to the men's tan uniform. We also had the two-piece white uniform. This was not a hospital white uniform but a dress suit.

MAJ Gurney: Did you have the classic green uniform which just became obsolete for us last October?

BG Dunlap: The green tropical wear?

MAJ Gurney: Yes. It was a green skirt and a Class A jacket with the tan blouse. We had that.

BG Dunlap: No, we didn't have that uniform at this time.

ARMY MANAGEMENT COURSE

BG Dunlap: While I was at MFSS, the Army sent me to Fort Belvoir to take the Army Management Course. Lieutenant Colonel Harriett Dawley, who was the assistant chief of the Army Nurse Corps at the time, did the course at the same time. The two of us were the two women in the course. People from throughout the Department of Defense took this course on total Army management. While in that course, we would call [Colonel] Peg Harper, Chief of the Corps, telling her that we really liked being the two women who were living in the quarters with all those men. (Laughter)

It was like a lot of the Army courses. We were in class all day. Then, at night, we got together after dinner and discussed some of the situations that were part of the curriculum there. That was a good experience. Also, the Army sent me to Fort Benjamin Harrison to take the financial management course. That was pretty

good. I don't completely remember the name of the course now. It was a manpower survey course given by the AG [Adjutant General] School at Fort Benjamin Harrison. They worked real hard to educate me!

Okinawa

I mentioned that I received orders to go to Okinawa. I didn't really know where Okinawa was, or anything about it. I knew just what General McGibony had told me about it. Although it was a 250-bed hospital, they usually ran around 140 to 150 patients. I'd be able to play golf every afternoon and really have an opportunity to travel. You know, to Hong Kong, Bangkok, Taiwan, up to Japan, and just have a real good tour over there. So I left Medical Field Service School in October of '65. I flew out of San Francisco to Okinawa.

The chief nurse in Okinawa was Lieutenant Colonel Doris Brandon, who had been a supervisor of mine at Brooke way back in 1946. She is retired—lives in Dallas now. But she is a dear, sweet person, a tremendous chief nurse, a perfect lady, and a very difficult person to follow in an assignment. I knew that when I went in as chief nurse in Okinawa, I would be going into a good nursing service under a chief nurse like Doris Brandon. This was my second assignment as chief nurse of a hospital, the first was when I was a captain at Camp Chaffee, Arkansas.

In Okinawa, I had a larger hospital. In the meantime, remember, I had some duty in hospitals, but not as a chief nurse. So this was a new experience for me. Having been five years at the Medical Field Service School teaching nursing service administration, I kept thinking to myself, "Ol' gal, this will give you an opportunity to try to put into action what you've been preachin' now all these five years." I had many thoughts about going into this assignment. This was an eighteen-month tour. I was there only eleven months because my tour was curtailed seven months to bring me back to The Surgeon General's Office to be chief of the Army Nurse Corps Assignment Branch. But the eleven months was really filled with a lot of experience in being a chief nurse and expanding a hospital.

Vietnam was in its early stages. At that time the only offshore hospitals were Clark Air Force Base in the Philippines, our hospital in Okinawa, and Camp Zama, Japan. Patients coming out of Vietnam normally were evacuated to Clark Air Force Base, where they would remain overnight—RONs as we called them. Then they came up to Okinawa. If they could be hospitalized there and then could be returned to duty, they were. If not, they would RON and go on up to Camp Zama. Some of those were returned to duty from Camp Zama. But those being evacuated back to CONUS [the continental United States] would be evacuated from Japan out of Tachikawa Air Force Base, where they had the big unit at the time.

EXPANDING THE HOSPITAL

As Vietnam began to really heat up, and before we had many hospital units on the ground in Vietnam, you can imagine the large number of patients that we were

getting in. When I got there in October, our hospital was 250 beds. We ran a census around 150 patients. But by December of that year, we had increased our capacity to 600 beds. I remember one morning, going in to the commander to give my morning report as I did each morning, and I told him we had 599 patients in his 600 beds. He thought I was pulling his leg. But I was not pulling his leg. That included not only the patients from Vietnam, but those from the island itself. Plus, we had obstetrics. There were dependents living on the island. We had obstetrics, a GYN [gynecology] ward, and a small psychiatric unit.

MAJ Gurney: What did you do to expand those beds? How did you do that?

BG Dunlap: We put more beds in places like the day rooms. We also turned one-bed rooms into two-bed rooms. A large number of those patients were malaria patients. There was a high incidence of malaria in Vietnam. We had a building for the enlisted detachment to live in. We converted that into a building for malaria patients. We had some quonset huts around the area that had been occupied by some of our enlisted personnel. We converted those into places for more of the convalescent patients.

The story of the malaria is that Japan would not receive any of the patients with malaria. There was no malaria in Japan. They didn't want it introduced into their country. We received the malaria patients in Okinawa, treated them, and most of them returned to duty. So we saw them go through the acute stage, when they really required nursing care, to the convalescent stage and reconditioning to go back down into Vietnam.

We received the Koreans who were being evacuated out of Vietnam. They did not want them going into Japan and then on to Korea. So they came to our hospital. When we'd get a planeload of them, they could be evacuated on to Korea, where they'd be cared for there. Since I'm mentioning the Koreans, I'll go into just a little about them because they were known as tremendous fighters in Vietnam. They were tremendous patients. They were of great concern to us because they didn't speak English. They would not complain. We knew they were having pain, but we were having difficulty trying to know just what their symptoms were or what their complaints were so we could respond with treatment.

One planeload came in with a Korean corpsman evacuated from the front. He spoke English. He was a Korean equivalent of a medic. So we worked with him. We kept him in our hospital long after he needed hospitalization to serve as an interpreter for us. What we worked out was a set of cards that said in Korean, "Does your leg hurt? Where do you hurt?" Then there was an English side to the card to let us know what it represented. We'd show it to the patient and point to the Korean question. We could see what was being asked. We learned to work with them that way and with him. We certainly used those cards a lot, particularly after he was gone. They enabled us to determine what the patients' needs were. Those patients just didn't complain. They were tremendous patients. That was quite a positive experience and a nursing challenge. It was a challenge for the physicians, too, for the physicians were depending on

nursing to work with the patients and to determine what were some of their complaints.

MAJ Gurney: Were the Koreans the only group with whom you had that language barrier?

BG Dunlap: Yes.

MAJ Gurney: You didn't take care of Okinawans?

BG Dunlap: Okinawans were under the protection of Japan. They didn't go down into Vietnam.

MAJ Gurney: Did you take care of the local nationals? Or anybody within your community?

BG Dunlap: Oh, within the community? Only on an emergency basis. At Koza and Naha, they had hospitals. We took care of Okinawans only in an emergency. There were a lot of automobile accidents, motorcycle accidents, on Highway 1. That highway went around the island and motor vehicles would hit them. They might bring them into the emergency room. We'd hospitalize them just until they could be moved on to their local hospitals.

So, the Koreans were the only ones who really gave us any language difficulty.

As our hospital expanded, our staff didn't expand. This became quite an interesting exercise for me. Remember, I had been in World War II and I knew how thin we were staffed then. We had one nurse and one corpsman taking care of a hundred patients. That was under field conditions. Here we were in a beautiful, modern hospital. I knew it could be done. But I didn't know about the staff. If the staff in '65 were like a staff in '45 or '43 or '44 it would work. But the whole culture had changed, and professional attitudes and training had changed over that period of time. I shouldn't have worried because the staff responded. There were times we went to long, twelve-hour shifts. We all worked overtime. There was no question about it. They responded beautifully. I had no question in my mind that the patients were receiving just as good care as if we had been staffed according to the staffing guide, probably better. Everyone works a little bit harder, tries a little bit harder, under circumstances like that.

MAJ Gurney: Did you ever get an increase in allocations to the hospital?

BG Dunlap: No. Not as far as nurses were concerned. We did have civilian nurses. Most of them were dependents that lived on the island. I only had two nurses who were career Civil Service. They came over to work on Okinawa. We did have an increase in some of the civilian nurses. But, as far as Army Nurses, there was no increase in staffing in Army Nurses. A medical unit came in with just their officers and the enlisted personnel. They were supposed to go to Vietnam. We had

some of those enlisted personnel working with us to help the staff. They worked with us until they pulled out.

The staff and the care of the patients was great. I took great pride in what was accomplished. When we started getting air-evac patients, they usually came in the evening. When I looked at the system, I thought, we couldn't have this chaos. First of all, we never knew how many we were going to get. Nor what kind they were going to be. Were they going to be surgical patients or medical patients? Although we had joint medical regulating—they were suffering growing pains.

EMERGENCY RESPONSE PLAN

I went down to see the first group of patients to arrive by air-evac. When I got there, I thought, "This is utter confusion." The ambulances pulled up to the back of our clinic area. They brought the patients in, including the litter patients, and just lined the halls with them. We had physicians down there to see them. But we didn't know whether we should have the orthopedic staff down there, or the medical staff down there. We didn't have any OB/GYN coming out of Vietnam. So they didn't have to worry about having them down there to begin with. But managing the casualties from the time that they entered the hospital until they actually got up to the wards was very difficult. We were prepared on the wards, knowing that there was an air-evac coming in. But the wards didn't know if they were going to get any or not. It could be quite a length of time before the situation stabilized.

I thought, "This is not the way this should be." Nursing down in the reception area was very limited. There were no nurses down there. So, I went down. I went down for every air-evac that came in. I went with a physician then. We set up a roster for physicians. The physicians had to come down regardless of the type of patients. We designated a certain number that had to come down from each service to help screen the patients and get them up to the wards, or to x-ray, or wherever they should go. I went down there with my NCO.

Once down there, I went right along with the doctors. That shocked them that the chief nurse was down there with them. We had already looked at the tag on them or we'd have the x-ray there, or something. We'd look at that patient. The doctor said, "This goes to Medicine." Immediately, my NCO checked his list of where we had vacancies on Medicine. We could tell right then what ward they would go to. So, we really worked out a system.

To me, the key to that was the support of the commander and the chief of Professional Services. We needed their support to declare that when we have air-evacs coming in, physicians would come down to help with the screening of the patients. For me, I was down there for most all air-evacs. I guess I like to see efficiency. I like to see if there was something we could improve in the system along the way.

If I couldn't be down there, then there would always be one of my supervisors down there to really take the responsibility, with the NCO, to keep things moving to get the patients out and admitted to where they should go. At that point, the patients

probably didn't need any immediate care. They were stabilized. We didn't need any quick intervention at that point. They could wait until they got to their ward.

There were some cases where the flight crew came over with them. They brought their records—medical records and so forth. They passed on information to us for any of the patients who had really had some troubles in flight. Those were the patients who would be seen first and rushed up to the ward, to x-ray, or on into surgery, whatever might be needed. That was one of my big projects. I wanted to make that process flow just as smoothly and quickly as it could for the patient's comfort instead of having all that confusion down there in admission.

Then, the next day, we reversed the process. Some of the patients were there just to remain overnight. So we set up a Remain-Overnight Ward. That cut down or minimized the confusion that existed on the regular ward. We set up the RON ward to concentrate all that patient movement in one area.

MAJ Gurney: Looking back, if you were to organize that process again, would you do it the same way? Or would you change who did what and what they did? What their function was?

BG Dunlap: As the process finally developed, I think it was the best under the circumstances. There were space limitations. We still had to use the corridors and so forth. Possibly we could have brought admissions and the registrar into it from the start. But we had a good admissions office. Our registrar, I'll discuss that in connection with this—wasn't that effective at that time. Our process was that we had the physician staff present when the patients came in. We had our senior nurse and NCO there because they know the hospital the best. The wards were alerted and we knew how many empty beds we had and where they were. With that, we knew immediately where the patient should go.

At that point, admissions wanted to get information from them. That slowed the process down. Sometimes we'd say, "No. They'll go straight to the ward." They could go to the wards to get the information they needed depending on the patient's condition.

If I were to do it again, I would definitely have an RON ward. We never knew when we were going to get patients in. If we were constantly taking them in and out of a ward it would really disrupt our normal operation. For the RONs, the next day they left, so we could concentrate our turnover efforts on that one ward. Getting the patients out again included getting their records together and assembling any gear they had with them. The whole procedure from the day before was reversed. We got them down to the first floor loading ramp, where the ambulances pulled up to take them off to Kadena Air Base. That entire operation took a good deal of time and effort from everybody concerned.

As we began to have more and more casualties from Vietnam, we got more and more patients through the system. But, as time went on, Vietnam began to get more hospitals in country. So the patients who used to come to us were then being taken care of in the hospitals in Vietnam. Those being evac'd to the States still came through the system to us.

THE FIELD MEDICAL RECORD

MAJ Gurney: Thinking of the early period before you had a large volume of hospitals in Vietnam—what was the medical record that they brought to you? Were they still using the Field Medical Card?

BG Dunlap: Yes, they had the Field Medical Card.

MAJ Gurney: Did you initiate a medical record for them?

BG Dunlap: Oh, yes. But not for the Remain Overnights. The remainder, though, received the full medical record. Some of them stayed with us an extended period of time. Some were returned to Vietnam. But others went on to be evacuated back to the States. Any notes that we made during the RON went into the Field Medical Card.

MAJ Gurney: There was a continuation sheet you could staple to that. Wasn't there?

BG Dunlap: That's right.

MAJ Gurney: It was interesting getting those records sometimes. Sometimes we got the wrong tags on the wrong patients.

BG Dunlap: Oh, no.

MAJ Gurney: Not many. But sometimes that happened. (Laughter) Did the record change later on then, as things got more sophisticated?

BG Dunlap: They came to us with their medical records. The record was initiated in Vietnam in the hospital there. Then, we added to it to cover their hospitalization. So it became just like any chain of evacuation.

It was always a chore to be sure that all x-rays were kept with them, too. We had to make sure that we kept those with them and got them out. Records have always been a bugaboo, I think, and they are even today. It has been a challenge to keep the records and the patients together during peacetime and during war.

I mentioned that in this air-evac procedure, I felt that the registrar was a weak link. That was the result of poor leadership in that office. As chief nurse, I found it very upsetting to suddenly have more patients on an air-evac than we had beds. There was something wrong in the reporting system. Our registrar was to report to JMRO [Joint Medical Regulating Office], every day, the number of vacancies that we had. They were supposed to regulate only that number of patients to us. Of course we also had OB/GYN and pediatrics. That was included in our total patient census. We might say that we had a 600-bed hospital and we had 75 vacancies. But the beds the women were in may have been reported as vacancies. We didn't have that many vacancies because we had women and children in some of

those beds. Plus, we had a certain number of bassinets. I don't remember the exact number of bassinets we had.

I had tremendous commanding officers. The commanding officer during that period of time was Colonel Clark Williams. He was just such a tremendous person, administrator, and professional. It confused and upset him, too, when I had to report to him. He depended on my report to know what was going on with those air-evacs. So I set up a scorecard. My NCOs and supervisors and I set up a scorecard as we called it. You can tell I'm a baseball player. (Laughter)

You have to have a scorecard to know the players. We had to have a scorecard to know the players in our hospital. It told us where we had vacancies. It was just a very simple thing. It had the ward number, the bed capacity, and the beds occupied. My night personnel prepared that for me. In the morning when I went in to report to the commanding officer, I could tell him where every vacancy was in that hospital. Bob Ward then directed that number was what would go to the registrar. That is what the registrar put in his report to JMRO. As a result, we could at least coordinate our capability to receive the air-evac patients. If we had six empty beds on post-labor and delivery ward, that wasn't going to help. We sure as heck couldn't be putting malaria patients up there, or anything else. It began to kind of smooth out a little bit after that. It became a joke around the hospital, that little scorecard.

This scorecard was updated every shift. It was a responsibility of the nursing supervisor and nursing NCO to update the scorecard so that the oncoming nursing staff knew just exactly where the beds were in the event an air-evac came in during their tour of duty. It was such a simple thing. But it was time-consuming to be sure that you had it. To me, it was a really important tool for patient management. Because of the use of this, we began to see things smooth out. If we were reporting what we could actually receive, and we received that number, we could provide better care to the patients who came in.

VISITING DIGNITARIES

Another challenge for us was VIPs [very important persons]. All the VIPs wanted to go to Vietnam to see what was going on. This included congressmen and military commanders. Now the military commanders had a right to go down there, but I sometimes questioned whether it was appropriate for the congressmen. Other people also got permission to go to Vietnam to observe. It seemed that they always stopped on Okinawa for a weekend. We received word from headquarters protocol that Senator so-and-so was going to be coming to Okinawa on Sunday and would be there at a certain time. Their itinerary included a visit to our hospital at a certain time. He would like to see all of the patients from his home state during his visit.

MAJ Gurney: Oh, no!

BG Dunlap: Well, as the chief nurse, that's all I needed. With the tremendous nursing staff that we had, we were able to work out a system so that as the patients

from Vietnam were admitted, we color-coded the card at the foot of the bed that they were from Vietnam. Then we put the state and their hometown on the card. If we received such a call the NCO could call up to the ward and he'd say, "Do you have any patients from Iowa?" And immediately the wardmaster could tell him "We have two" or "We don't have any." We would be able to identify those patients, and then we knew whether we'd take that particular VIP to that ward to see the patients on that ward. Or, if we had a group of ambulatory patients from a particular state, we might put them in the day room on one of the wards. That way the congressman didn't have to go through all the wards. Master Sergeant Robinson was my NCOIC at first. He was a tremendous black sergeant. Then, Master Sergeant Jack Hill was my chief NCO. He followed Sergeant Robinson. He'd been the NCOIC of Medicine. We had our VIP tour down so pat that the doors were opened and propped, the floors were polished, and the elevators were held. We had people assigned so that when the VIPs came in, the commanding officer and my NCOIC and I would meet them at the front of the hospital. We took them to the commander's office where they received a briefing. Then we went on the tour, escorted them to the front of the hospital, and saw that they got in their cars and got on their way. (Laughter)

Then, we'd relax. I'm kind of making light of it. But we were concerned about patient care. Sometimes we thought, "Is this necessary?" Particularly when they wanted to see their constituents. If they wanted to visit the hospital and see everybody in the hospital, or even all of the patients from Vietnam in the hospital, that would be one thing. But, just to see their constituents, to me, that was just as political as it could be. I kind of objected to that. The whole Vietnam War was political anyway.

I guess that was just another manifestation of what was going on in Vietnam. I can remember when representatives came from the American Legion and a church group from a particular state. They wanted to see the people from their state. As we toured they visited with the patients. "Oh, yeah, remember so-and-so." They happened to be from that particular area—their hometown area. I'm sure it meant something to the patients. It would especially mean something if that representative went back and told the family that they had met their son or their relative over there. It had its good and bad. But I didn't really think of it as part of nursing care at that point.

MAJ Gurney: Were there any VIPs or visitors that you were particularly happy to see?

BG Dunlap: One I was very happy to see was our Chief of Staff of the Army, General Harold K. Johnson, and his wife. Often the wives came, too. I don't think they went to Vietnam. They came on a Sunday. We had been alerted that Mrs. Johnson was having trouble with one eye. She didn't know what the problem was. We had that coral sand. They thought maybe she had gotten some of that in her eye. So, we set it up for the chief of Ophthalmology to meet us. Immediately one of my nurses took her up to the clinic so that she could be taken care of. Then we

took the Chief of Staff for the briefing and the tour of the hospital. As soon as Mrs. Johnson could join us, she did.

They were such a beautiful couple. They communicated so easily with the patients. The patients were so at ease with them. There was such sincerity there that you could see it. They were really interested in seeing the patients. The patients responded to that. We as staff responded to it, too. I know their itinerary designated that we were to have them through with the tour in time for them to get up to the main post chapel for church services. For me, this kind of fit the total picture. They were interested not only in patients and staff but also in the religious activities on the island and in the families. They were interested in the troops there on the islands, to sense what was available to them. Of course, they were both very grateful for the care that Mrs. Johnson received. It was some little thing that she had gotten in the eye. It was very minor and we could take care of it for her.

I will mention one thing that I particularly objected to that was part of that whole setup. On Okinawa we had a gift shop. The Military Wives Club ran it. The wife of our hospital commanding officer managed it. They had beautiful things in there. They traveled to Bangkok, Hong Kong, Taiwan, and Japan to buy these things, making it available to our American forces stationed there. The shop was closed on Sunday.

This was usually included in the itinerary for some of the visitors, but not all of them. Some of our visitors wanted to visit the gift shop where they would purchase many of these things on the military base and have them shipped back to them. I can remember our commanding officer coming to work on Monday morning with bundles of things these visitors had purchased that his wife had packed. He had to take them to the mailroom to mail home to them, or get them on planes going back to the States. It was that type of thing that was the bad part of the whole picture of the Vietnam situation. I could just see the commanding officer at Walter Reed mailing packages, or being expected to do things like that. Our commander and his wife were such tremendous people. They did anything to help the AMEDD or anything we did over there.

EMERGENCY DRILL TO SUPPORT THE SPACE PROGRAM

Okay. I've got to get going faster on Okinawa because we want to cover a lot of things here. If you remember, this was during many of our early space flights. I think it was a Gemini flight. I don't remember for sure if it was Mercury or Gemini. There was a flight aborted over the China Sea. Not knowing what was going to happen, we were alerted to be the medical facility for this flight. You might remember those tiny two-man capsules.

The emergency plans were pulled from the commander's files. The plan was for the capsule to be brought into Naha, which was the Navy base there. Any medical care needed would be our responsibility. At the time, this was real dramatic. As we were listening to it and watching on TV, we were wondering what our responsibilities were going to be. Our plan was put into action, and it included evacuating one whole ward.

We immediately set it up as a resuscitative intensive care unit. The MPs were stationed up there. We set up a room to control any press because we knew they would need to be kept away from that area up there. We also got them away from the patient care area. We had our whole surgical team alerted and ready to function. That ward was set up not knowing what we might receive. We wondered if they would be burned in re-entry. Would there be orthopedic trauma? Would there be chest injuries? Head injuries? We didn't know what was going to happen. But we were prepared for it.

Once we were prepared, the commander, chief of Professional Services, the executive officer, and I sat in the commander's office to follow what was happening on TV. The capsule was brought in to Naha to the Navy base. It was determined that the two astronauts were in good physical condition. Choppers then flew them across the island to Kadena Air Base. They had a little dispensary there. They were checked again at the dispensary by the flight surgeons. Then they were put aboard a big plane and flown back to Hawaii. So our operation then had to go in reverse. But it was a good experience.

That was really quite a dramatic experience to prepare for something so unknown to us. We didn't know what the extent of injury would be for the two patients. We didn't know what would be needed. We were grateful that nothing was needed, but we really had our emergency exercise right there. Just as a sidelight, the capsule was brought to Naha Navy Base. I received a phone call from the base commander the next day. He said that they were going to put it on display to the senior members on the island and wanted to know if I wanted to come down and bring my family with me to see it. Of course, he didn't realize I was single and had no family over there. I thanked him and I said I would be very happy to do it. So, I got my nursing supervisors and NCOs. They were my family, and we went down and saw that tiny capsule. When we thought about it bobbing around out there in that great big ocean it seemed even smaller. I have a picture of me standing beside the capsule covered with the black soot from re-entry. That added a little excitement to my tour in Okinawa.

91C SKILLS

During the time I was there, I was concerned about the 91 Charlies [Military Occupational Specialty 91C]—our enlisted personnel. We were getting replacements and I expected 91 Charlies to be able to function as 91 Charlies in a situation such as that. As we got replacements for our staff, we got some really fine men and women—91 Charlies. But many were inexperienced. Perhaps they had been assigned to dispensaries. As you know, in hospitals, 91 Charlies are in demand. But not by everyone. Nursing needed them as experienced 91Cs. Elsewhere, they needed them, but not to work as 91Cs. That's one of the problems. We have to keep them in their primary MOS. If I get on my soapbox, stop me. (Laughter)

I felt that I wanted to be sure that the 91 Charlies coming into the hospital were prepared to function as 91 Charlies. So I set up a review for the 91 Charlies.

There was some resentment at first. But it depended on my educational coordinator and the NCOs working with her to implement it. 91 Charlies who came into the hospital for assignment there received an evaluation. A good deal of it was a hands-on evaluation. But they were evaluated regarding whether they could actually do the procedures expected of 91 Charlies.

They had to demonstrate the skills. It wasn't just a pen and paper test. Once it became evident that they were qualified to function as 91 Charlies, with minimum supervision, they could be assigned to full duty. We needed to know they could function with minimal supervision because that was how we had to use them. They may have sole responsibility for the RON ward or some of the outlying malaria wards. They would get minimal supervision if they had one of those wards.

I felt that as we ironed out the kinks that became a very productive program. Those who came in who knew they had the skills didn't take offense at being evaluated. Those who felt that they needed a refresher—and I hesitate to call it a refresher because people resent that—were grateful that they had the opportunity to do some of these things before they were put on the wards and expected to do it. In the beginning, there was a little resentment about the program. After all, they were 91 Charlies. Some of my own staff thought it was really necessary to do this assessment.

COMPARING THE MEDIC OF THE '60S TO THE MEDIC OF THE '40S

MAJ Gurney: Before we leave the subject of enlisted training, I'd like to ask you something. In twenty to twenty-two years, you'd worked with a great number of enlisted corpsmen. Was there a change or an evolution in their role from the time when you were over in the South Pacific to the time that you were in Okinawa? Twenty years had elapsed. What evolution did you see in their role?

BG Dunlap: I saw a difference in their preparation. The enlisted personnel I had in New Guinea had minimum training. Many of them were drafted. We sent them through programs like we had at MTC [Medical Training Center] at the beginning to train them to be medics. I guess they were equivalent to our current 91 Alpha. Some had progressed to the 91 Bravo level. We had a few who had worked in stateside hospitals. But not too many of them. They immediately were put into units and had to learn just as many of the nurses. We also had limited experience in Army hospitals before we were put into units and shipped overseas. That isn't true of some of the hospital units because the hospital units from our universities and so forth went over as units. For instance the Baylor Unit, the Massachusetts General Unit, and the Harvard Unit were professionals who had worked together in hospitals before they were deployed. That wasn't true of most of the units. The enlisted men were expected to do even more than some of our enlisted personnel today, and they did it with less training.

MAJ Gurney: So what would they be expected to do?

BG Dunlap: They were often the only enlisted person on the ward with a nurse. They could be doing dressings, removing sutures, starting intravenous lines. The nurses usually started the blood. But I wouldn't say that some enlisted men didn't start blood. Our physicians were in surgery most of the time. We didn't have interns in those situations. Our nurses and our enlisted personnel were doing many of the things that in peacetime our physicians would be doing, such as inserting nasogastric tubes or taking care of the oxygen. Remember, we didn't have oxygen tanks per se. We had oxygen tents and other things. We had the oxygen tanks fastened to the side of the steel cot. (Laughter)

So they had to do those things, plus help in the screening of the patients with the nurses. The physician would come onto the ward as we got a new bunch of patients in. He'd designate the patients for surgery. We'd have to get them to x-ray and to the lab. Then he'd leave. We'd start funneling the patients into surgery. As one came back, another one went in to keep it flowing. We didn't have recovery wards. Patients came from surgery right back to us. You don't have that in the hospitals today.

MAJ Gurney: Did the medics give medication?

BG Dunlap: Medications? I won't say they didn't. Certainly vitamins and things like that. They gave Atabrine because everybody had to have Atabrine, Atabrine and vitamins. They never gave narcotics. They may have given some of the sulfas. The medicine tray would have been prepared by the nurse, with the name of the patient.

MAJ Gurney: Then what did they do in Okinawa? What was their role?

BG Dunlap: The 91 Charlies? The role of the 91 Charlie was to function as a Licensed Vocational Nurse [LVN]. We utilized them on these wards—minimum care wards—in a role similar to a head nurse of the minimum care ward and the malaria wards. We also used them in our intensive care units. We had a recovery room and an intensive care unit there. Major Mary Jones was the head nurse, and she was a tremendous head nurse and a tremendous person. She had the 91 Charlies in there working with her.

We might use them on air-evac runs. We couldn't always send a nurse and a physician out on every air-evac that went out to the air base or to bring patients in. Usually the Air Force would come in with the patients. But often we sent our 91 Charlies to take the patients out to the air base. We really depended on our 91 Charlies.

But 91Cs never gave any narcotics, or anything like that.

INTENSIVE CARE UNIT

MAJ Gurney: I'd like to go into the concept of the intensive care unit. Major Mary Jones was the head nurse. Is this the first time you'd been in a facility that

had an area that they called intensive care? You had progressive care before where you took the contagious patients. What was this intensive care area?

BG Dunlap: It was right outside the operating room. It was a post-anesthesia area. Remember, we not only had Vietnam patients, we had all those terrible motorcycle accidents. I have a phobia about motorcycles because many of our worst injuries in that hospital weren't from Vietnam. They were from motorcycle accidents.

I'll digress just a minute. The Marine commander came through the hospital. He wanted to see the Marines in the hospital. So we took him to see the Marines. They stood at attention at the foot of the bed and he talked to them, "Son, Where did you get your injury?" Well, it kind of shook up one Marine commander when we had four Marines with fractured jaws in our hospital. They were all from fights on the island. I could see one little Marine standing tall at attention as he mumbled out of the side of his wired jaw saying, "But, Sir, another Marine did it." (Laughter)

He wasn't going to admit that someone from the Air Force or the Army had fractured his jaw. (Laughter)

Our intensive care included post-anesthesia and those who needed to remain for intensive care in that same area. We just had the post-anesthesia in one section and the intensive care in another section of that particular unit.

MAJ Gurney: Did those nurses have special training?

BG Dunlap: They weren't graduates of the Army Nurse Corps Intensive Care Course. This was in 1966 and there was no course. They were senior nurses like Mary who had experience taking care of sick patients. I can't think of any of the young ones as they came in. I was just there eleven months. We carefully assigned nurses there. With Mary as the head nurse of that unit, if I assigned someone up there who she felt shouldn't be there, all she had to do was to tell the supervisor and we'd make staff changes.

MAJ Gurney: Did they have a special nurse-to-patient ratio on that unit?

BG Dunlap: It did have a special ratio but I can't tell you what it was. It was much heavier staffed than the other units. It had to be. It varied according to the workload up there. You do that in a small hospital. That's another difficult thing, to take a nurse who normally works in intensive care, and then bring her out to help you on a medical ward. (Laughter)

MAJ Gurney: What kind of special things did those nurses do? Can you recall at all what their activities were? What made them different from the wards?

BG Dunlap: Well, we got patients with head injuries, spinal injuries, amputees, chest injuries, all in the acute stage when they really require intensive care. We also

had some coronaries over there. There were burn patients from some of the plane accidents and accidents at fuel dumps. They took care of them in the critical period. They wouldn't be released from the unit until they no longer required that critical nursing care. Because, on the wards, we often had one nurse—particularly on the 3-to-11 shift. During the 11-to-7 shift they might be covering two wards. You couldn't have that kind of patient out on those wards.

WEIGHT CONTROL PROGRAM

One other thing—about this time, one of the things the Army was stressing, as they are today, was overweight. You saw pictures of me. I can talk about being overweight because I was not overweight at that time. The program came down that we were to get our troops in good physical condition. This was one of the early attempts to try to establish what the maximum weight should be. Anyone over that maximum weight had to be counseled. This has been tried so many times over the years. I think now it may have more teeth in it than it did then. But we were directed to do that. The commander had the direction. So, it became my responsibility to enact the program for the Army Nurses, the troop commander's responsibility for the enlisted personnel.

My concern was the Army Nurses. As the senior woman officer, although we had AMSCs, [Army Medical Specialist Corps], I was considered, as in the past, as the representative of the women on the staff. How was I going to do that because I had some very overweight nurses? We had one OR nurse who was tremendous. But her arm was as big as my leg. (Laughter) She was a tremendous OR nurse though. So, how was I going to approach this? I believe so firmly in working with my supervisors. We worked together. The way we set this up was that every one of the Army Nurses had to report to the outpatient clinic supervisor who was a lieutenant colonel nurse. She weighed them, took their blood pressure, and then she provided that information to the chief of Medicine. The chief of Medicine evaluated it. Appointments were set up for the individual to see the chief of Medicine. We functioned strictly at the chief level.

The chief of Medicine saw the nurses that he felt he should see for overweight or underweight. I did have a couple of underweight ones, too. Based on that, he recommended certain programs for them. At that point, I got into it. I had to know what the recommended program was for the individual. The program was between the individual and the chief of Medicine. In theory, the only individuals who knew it were the chief of the outpatient clinic who had made the report, the outpatient nurse supervisor, the chief of Medicine, the individual concerned—and me. I think that privacy was pretty well kept. If anyone talked about it, it was usually the individual.

The individual worked with the head dietician to set up a diet for them. They'd work together to try to see to it that they could get the diet that they needed. Some of them lost weight. But my nurse that was so overweight (laughter) would not. On Sunday morning she would cook the biggest breakfast and invite all of the doctors who were over there without their families at that time, particu-

larly the surgeons and the OR staff. They'd come in and they'd have a big breakfast. She ate her big breakfast at other times, too. It wasn't a complete success. How do you measure success? It helped some. But I don't think any weight program is going to be 100 percent successful.

EMERGENCY LEAVE

One morning I received a call through the Red Cross that Mother had experienced an MI [myocardial infarction] back here in San Antonio. They recommended that I come home. This shows, again, how closely we worked with the commander and our registrar. We found that we were going to be getting an air-evac plane in. It would have burn patients on it. The plane was going to be going straight on to Japan. The patients were being evacuated back to San Antonio to the burn unit. So, immediately my supervisors said, "Get out of here. Get yourself ready. We'll take over." And, they took over. Personnel cut orders on me to come back as an attendant on the flight.

But I was only a paper attendant. When we got to Japan, the Air Force flight crew changed. I went to where the patients were and stayed with the patients in case they needed anything while the Air Force was doing what they had to do. The same thing happened when we got to Travis Air Force Base. Then, when we got to Kelly Air Force Base I rode in with the patients along with the staff to Brooke. My folks picked me up and I could get over to see Mother. I think I was home two weeks. Mother did beautifully. Then I was able to reverse the process by getting a flight on an air-evac back out to Travis Air Force Base. Then back to Japan and Okinawa.

The Air Force was tremendous, and everybody along the way took care of us. We take care of our own, as you well know. That was a beautiful example. My staff took over in my absence and carried on. That was another experience in Okinawa. Aren't you glad I wasn't there eleven years with all these experiences? (Laughter)

CARE PACKAGES FOR VIETNAM

I was over there for the Christmas of '65. Lieutenant Colonel Margaret Clarke was chief nurse in Vietnam. She was the first chief nurse of the Vietnam Command. She came to Okinawa on her way to Vietnam. So, I knew Margaret Clarke. I'd gone out to Kadena to see her. I got in touch with her and asked her what the Army Nurses in Vietnam needed. At that time they hadn't set up all of the PX facilities in country with supplies and whatnot. So she sent me a list of things that she thought that might be good to send down to them. Our nurses in Okinawa took up a collection. I sent the young male and female nurses over to the PX with the list and the money to do the shopping. They had a ball doing the shopping. We also sent them to the commissary to shop for things to send there. We accumulated tons of things to send to them.

We had a party and we gift-wrapped many of the items that were purchased over at the PX. In my quarters, we had a candy-making party. (Laughter) I can tell

you you're not going to realize much success making divinity in Okinawa during the rainy season. If you know divinity. (Laughter) You have to whip it and whip it and it's supposed to be light and fluffy? Well, our divinity never got light and fluffy! (Laughter) It didn't matter how much we whipped it. But we had fun—all the members of the nursing staff had a great time up there in the quarters making up candies and cookies, gift-wrapping and packaging them.

We got all this stuff together but then we had to figure out how we were going to get it to Vietnam. We took some of it out to Kadena Air Base. We coordinated flights to Vietnam with Margaret. She knew where the flights came in. The air-evac planes took some of the goodies down. We also went over to the Marine air base.

We got packages sent through the air-evac system at Kadena Air Base and through the Marine flight squadron there in Okinawa. The chief nurse in Vietnam then wrote to us, and many of the nurses in Vietnam wrote to us, saying what a delight it was to receive the packages. They shared them with the patients.

MAJ Gurney: How neat!

BG Dunlap: The patients weren't getting many Christmas packages at that time. We had sent so much stuff there that whether it was a candy bar or food item or something else, it was appreciated. We might even have sent a hairnet or some spray and it was appreciated. You've read or heard about the famous hair spray scandal of Vietnam. There were many of these types of things that they didn't have, or they were hard to get. At least they got something. Our nursing staff in Okinawa really received a great deal of satisfaction knowing that we were able to do that for them. We had a good time doing it, too. Some of those packages weren't very professionally wrapped!

TYPHOONS AND EARTHQUAKES

I have a few other items about Okinawa to quickly add. They include typhoons and earthquakes. We had one of each while I was there. I had a very full eleven months! (Laughter) Just think, if I'd been there eighteen months, how many tapes we'd be using.

MAJ Gurney: Oh my yes! (Laughter)

BG Dunlap: I'll talk about the typhoon first. There are typhoon procedures well established. People live through typhoons on Okinawa, and they talk about how many typhoons they've lived through. They board up and tape the windows and so forth and so on. I found that the procedure included moving the women officers—nurses, OTs [occupational therapists], PTs [physical therapists], and dietitians—into the hospital to sleep in the PT clinic. They'd plan for us to sleep on the PT tables or on cots that they might set up in the PT clinic. The theory behind that was that if the typhoon hit we'd be there to take care of patients. Many of the physicians moved into the hospital too. At that time we did not have dependent housing. It was built

later while I was there. But we didn't have it right at Kadena. So, the officers with dependents lived in post housing in other areas. Some of them lived on the economy. It would be difficult for them to get in to take care of the patients.

This meant that the nurses who lived just up the hill had to move in to the PT clinic so that we'd be able to staff the hospital if we had damages. We'd be there to take care of our patients. I went through one alert like this, but the typhoon did not hit. I thought, this will never happen again. There is no way that we can sleep down there, live down there, for several days and be in any condition to function. I thought to myself, why can't we set up a system that we came in only when we got to the last stage of the alert and then we'd use the armored personnel carriers that were on the post. They could come right up to the nurses' quarters and get us and take us right down to that hospital. That way we didn't have to spend the extended time down there. So, we did change that system. But we also had to set up a system to identify where our people lived, particularly the ones that lived on Okinawa.

Many of our enlisted personnel lived out on the economy. The streets aren't identifiable sometimes. They're in that little house that's back of this or that. They could only be identified by some landmark. So we developed maps. If we needed to pick up Sergeant Jones, the driver was sent out for Sergeant Jones. Many of them also didn't have telephones. The driver had a map of where Sergeant Jones lived and could go pick him up at that particular place.

I did experience one earthquake too. I was up at the Preventive Medicine facility behind the hospital. We heard a rumble. It really was a rumble. We could feel a little tremor. Some of them had been through earthquakes before. They said, "Oh, oh, I think we're having an earthquake." The staff car took me back to the hospital right away so I could be at the hospital. I don't know what the earthquake measured on the Richter scale. But we had rumbles and we had shakes.

When it started, I was on the first floor. I immediately ran up the six flights of steps to the nursery. My supervisors went to their units and the NCOs to their units. I went up to the nursery. As I got there the bassinets were rolling back and forth, back and forth.

MAJ Gurney: Oh, my gosh!

BG Dunlap: The light fixtures were swaying. In those days we still had formula rooms where we mixed up the formula. We had Similac I and II and everything else including canned milk falling off the shelves onto the floor. I had to run the stairs because we couldn't use the elevators. But we did have some patients stuck in the elevators. Remember when I talked about the construction of the hospital, there were expansion joints between the two wings of the hospital. This truly did take care of it because there was no great damage to the hospital. Those expansion joints did expand and the wings remained intact. That was quite an experience.

My commanding officer received a phone call from [Major] General Bryon Steger who was the Command Surgeon. He was in Hawaii. He had received a

phone call from Colonel Mildred Irene Clarke, Chief of the Army Nurse Corps, saying that they would like to curtail my tour by seven months to bring me back to The Surgeon General's Office in Washington, D.C. She wanted me to serve as chief of the Army Nurse Corps Assignment Branch. The question to them was, would they release me? General Steger called. The commander said that he could say nothing but "yes" because he realized what it would mean for me and my future to go back to such an assignment.

I was released and I returned to CONUS. I took a thirty-day leave and reported in to the Office of The Surgeon General, which was in the Main Navy Building, for assignment to be Chief of the Army Nurse Corps Assignment Branch. That begins a whole new story.

THE EVOLVING ARMY NURSE CORPS

MAJ Gurney: Before we get into that story then, I'd like to ask some questions. I believe that chief nurses of facilities run the Army Nurse Corps. What was happening in the Army Nurse Corps during the time you were in Okinawa? What may have come up that you then had to implement? Was the Corps undergoing many changes during this time?

BG Dunlap: The weight program was something that was directed to us. I can't think of the regulation per se. Training of our enlisted personnel was another issue as well as the utilization of our 91 Charlies.

Professional Development

I had a situation similar to the situation at Fitzsimons with male nurses. This pertained to some female nurses there in Okinawa. I had some majors who were not effective as head nurses. Whereas I had some lieutenants, first lieutenants, who were tremendous head nurses and potential head nurses. This was on the medical service. So, I assigned all the majors on one ward and assigned a first lieutenant as a head nurse on a medical service. It worked beautifully. We had problems with the major on this particular ward who was not an effective head nurse. She was not a role model for these youngsters. We were going to lose them. They wanted no part in military nursing if this was what the Army was like. They felt they could not work under someone like this who was not, in their opinion, professionally competent. She was not open to suggestions, would not let them demonstrate any initiative or ability. So, I thought, there's a way to overcome that, assign that head nurse, who is a more junior major, under a senior major. Let them work together. Then let the first lieutenant be the head nurse of the ward.

MAJ Gurney: So, you believed in assigning people according to their abilities?

BG Dunlap: Yes, according to their abilities. It also helped to know the personalities of the physician ward staff. I tried to assign people who I felt would be compatible in that working situation.

MAJ Gurney: So, in this case it was a Lieutenant Kathy Cannon who you assigned as a head nurse because she showed unusual ability?

BG Dunlap: She could run a ward as a head nurse better than some of the more senior people I had there. She proved that I was right because she later reached the rank of lieutenant colonel. I know she was assistant chief nurse in Europe when I visited over there. Her last assignment, I think, was at Madigan. She then retired.

MAJ Gurney: I think you're right. I met her at the RANCA convention in April.

BG Dunlap: Cardiology was her specialty.

MAJ Gurney: Oh, yes. She is such a wonderful person.

BG Dunlap: Tremendous. One of my youngsters. (Laughter) If you ever meet her again ask her about Colonel Dunlap—I was Colonel Dunlap then—and St. Patty's Day.

MAJ Gurney: Okay. That sounds like a story we need to capture!

BG Dunlap: Remember, in the beginning I talked about having come from five years' teaching nursing service administration and supervision? I felt a great responsibility to the staff who had not had that program. It taught staffing and about preparing young officers for increased responsibilities. I think this emphasis was felt throughout the Army. We were all emphasizing something like that. We realized that Vietnam was going on. Our young officers were going to be sent to Vietnam to function with more responsibility than they had to assume prior to that. That was a real potential. I felt a great responsibility to prepare our young officers for supervision.

I put some of the young officers on as head nurses. They certainly confirmed my faith in them and how they were able to relate, particularly with the physicians, because we had a bunch of young physicians around this period. Many of them had been in school together. The physicians and these junior officers had a beautiful professional relationship and understanding. I also brought junior officers in as supervisors. I had the medical, surgical, outpatient, and obstetrical supervisors during the daytime. I tried to have a permanent 3-to-11 shift with a senior nurse. That was when we got most of our air-evacs. To me, that's a very critical period in the hospital day. But then, for the night supervisor, I brought a first lieutenant in as my night supervisor. Her name was [First Lieutenant] Jackie Gordon. She was a very mature first lieutenant who had worked in obstetrics. I brought her in to be the night supervisor. Her relief came from the young head nurses that I had. Therefore, they all had an opportunity to be supervisors. I feel so strongly in staff development. I know we were pushing that at the school, teaching it at the school and encouraging that it be done.

MAJ Gurney: How did your staff feel about that?

BG Dunlap: The young ones loved it. Some of them were a little apprehensive. But they knew any time that they felt that they needed to, they could call the supervisor or they could call me. But we didn't get phone calls. My experience has been that when you give these youngsters responsibilities like that, they can do it. It really challenges them and motivates them, and they really put out. They respond to it. They could certainly give us some ideas, too, in their reports. I loved their reports the next morning, when we had our change of shift.

Staff development was something that I really stressed. I used this strategy so we could be sure about their abilities. We could see them handle increased responsibility. I was involved with these things all the time in my next assignment. In Okinawa I encouraged our young officers, med-surg nurses, to think in terms of what they really wanted in their careers. Did they want to stay in med-surg nursing, and how did they want to stay in med-surg nursing? I told them about what courses we had available in the Army that they might be interested in. If there were some who were interested, I would see to it that they initiated the applications for them so that they could go into them when they rotated back to the States.

Officer Efficiency Reports

One thing that the Army Nurse Corps pushes constantly is preparation of officer efficiency reports. Having come from teaching efficiencies to doing them, I wanted to get our young officers involved in the preparation of efficiencies. We've done it and we haven't done it. I felt very strongly that the immediate supervisor should be the rating officer. The supervisor of the rating officer should be the endorsing officer. Then, the supervisor of the supervisor, which would be the chief nurse in my case since we didn't have an assistant chief nurse, would be the reviewing officer. I felt very strongly that the individual should review the efficiency with their supervisor. I can remember "courage of their convictions" is one of the things that people are rated on. We've placed tons of emphasis on it. That means they're stubborn. Huh? (Laughter)

Hardheaded, stubborn, or whatnot. I felt that a rating officer should not be allowed to make a statement on that efficiency—negative or positive—that she had not counseled the individual about. As reviewing officer, these are the questions I asked along the way. If there was a weakness identified it needed to be counseled. I didn't want things like dirty shoestrings and slip showing and this type of thing on efficiencies. But if there was a weakness in that efficiency, the rater and the endorser had to assure me that the individual had been counseled ahead of time and given an opportunity to overcome that weakness. If as a result they had not overcome the weakness, it was reflected within the efficiency. I'm a stinker on that. (Laughter)

When I got into later assignments, I continued to be a stinker about that.

I'm trying to think if there was anything else during that time in particular. I guess not.

Attitudes Toward the War in Vietnam

MAJ Gurney: What were the attitudes of your nursing staff toward the war in Vietnam? This is very, very early in the war.

BG Dunlap: We had the old timers—those who'd been in before Vietnam. A lot of them wanted to go over there. I know I experienced that later when I was in assignments. Nurses didn't want me to assign them to Korea. They wanted to be assigned to Vietnam. If they had to go overseas, they wanted to go where the action was. Some of them did. Some of the young ones certainly wanted to be in Vietnam also. The only thing that kind of took the place of being in Vietnam was being able to be involved by taking care of the patients. Of course, in Okinawa we had Marines. We had the 173d Airborne. They went from Okinawa to Vietnam. Plus we had the Air Force. We had the Navy up at Naha. We really were an intermediary point for Vietnam. Because of that we felt involved. We were involved in the effort although we weren't down there in the combat area getting the medals for it.

I had a beautiful staff. I'm not saying I didn't have some problems. But there wasn't anything that couldn't be minimized even if it couldn't be resolved. Not everything can be resolved. But some things can be minimized. I discussed one of these with you. It was utilization of some ineffective majors. I had to determine how I would utilize them when they couldn't function effectively as a head nurse. So, their ineffectiveness was minimized by the way that they were assigned, putting them under a strong major who outranked them.

Death of a Staff Member

I mentioned to you, but not on tape, that one of our nursing supervisors died. She was Major Georgianna Sperl—she had been on duty. She went off duty, sat on the side of her bed, and collapsed. She experienced a massive cerebrovascular accident. This had an immediate impact on the staff. She was so respected and such a jolly person. She was such a good nurse and good supervisor. That leaves a void in any staff. But particularly in a small staff in a deployed area. It was interesting to see how hard this hit the young nurses.

MAJ Gurney: What did you do to help your staff through this grieving process? Or what do you think helped them through it?

BG Dunlap: We talked about it. I made rounds all the time in the hospital. For them, it was helpful to be able to talk about it. Every month I held a staff meeting with the whole staff. I brought my supervisors and head nurses together more often. But I had the whole staff together every month. This gave us a chance to say anything we wanted to say. Particularly, they wanted to talk more on a kind of one-to-one basis as I went around to see them on the wards myself.

I'll never forget the day that her body was being shipped back. I went out to Kadena. I watched them load the casket. I'll never forget watching that and seeing it take off.

Handling Controversy

MAJ Gurney: Were there any battles that you had to fight with your physician counterparts or with a commander? (Laughter)

BG Dunlap: The war was in Vietnam. I told you I had two commanders while I was there. I'll begin right there. The commanders were tremendous. They were two entirely different people. I had their support. I can even remember the position of my office in relation to the commander's. It was right across from the commander's office. Some people wanted to move my office away from there. The commander said "no go." No. I'd stay right there. I felt that I had a hundred percent support.

We had a chief of Professional Services whom I had worked with at Neubruecke. He had been in surgery. It wasn't Colonel Kamish. It was Colonel Nichols. He was chief surgeon and I got tremendous support from him. I think this comes about when you have served with people before and you each respect the other's abilities and weaknesses and you work together. The chief of Medicine was tremendous. As far as the chiefs, I had their support. When there were any conflicts or questions, they respected the nursing supervisors because they worked right with them. We were able to resolve the difficulties. Any difficulties were minor.

The one issue I told you about was the use of the male nurse on pediatrics. That was resolved. It had to go to the commander, but it was resolved in my favor to enable us to use the males nurses on pediatrics.

I won't say we didn't have disagreements. We might have disagreed on things. But we were able to work them out. The registrar was always an issue that needed a lot of interaction. The air-evac system was quite concerning to me. Now, if you talk to the registrar, he might have felt I was meddling. The ol' chief nurse was trying to boss everything. I probably was. (Laughter) But I was concerned about patient care and the effective utilization of personnel to get the patients in and out through the air-evac system.

The detachment commander and I worked beautifully together. He used to have me come over all the time if one of our nursing personnel had a promotion. I would help pin their stripes on them, or something like that. He'd come to my office and we'd talk over enlisted personnel matters. We'd discuss the personnel they might be having problems with.

MAJ Gurney: So the strategies that you used, that of trying to maintain harmony and get people working together to meet common goals, predominantly revolved around strong interpersonal relationships and communication?

BG Dunlap: You have to accept that sometimes, you're not always right. You know what you think is right and what's good for your area of responsibility. This goes back to my experience during my residency in hospital administration. It could be that what I think might be right for nursing service might present a real

problem for the detachment commander, or the registrar, the chief of supply, or someone like that. If the two parties can sit down and identify where the problem areas are, sometimes each one has to give a little bit. Sometimes they don't. Sometimes, one side is adopted completely. But that's the important part, which you sit down and discuss.

We had offshore dispensaries. These were a concern. On the island we had dispensaries like at Marshanado, Toro, and different places in the area. We had 91 Charlies and 91 Bravos out there. Then we had some little islands out there that had missiles. We maintained dispensaries there. I put the outpatient supervisor in charge of the dispensaries. She made staff visits out to the areas. She came back and reported to me regarding the quality of nursing. But she also reported to the chief who was in charge of the dispensaries in the outlying areas. Sometimes we had differences of opinion related to some of the processes being used or some of the supplies that were kept out there to meet the potential problems that might exist. But those were resolved.

We had two Army health nurses. [Major] Betty Lewis was the first one when I got there. She'd been a student of mine when I was teaching. She was a tremendous person and a good Army health nurse. Sometimes there is a little conflict between Army health nursing and hospital nursing in the organizational relationship. She came under the chief of Preventive Medicine for those functions because she really had an expanded role in preventive medicine—not just nursing. But she was assigned to me as chief nurse. If I wanted to use her as a relief supervisor, that could be done if I had to. But I respected what she had to do and didn't make those demands on her unless there was a real need.

Trying to work out that relationship needs a mutual appreciation of each other's workload and responsibilities and respect that she was working to her capacity taking on some of the preventive medicine aspects of the command. But I never called on her to do anything that she didn't need to do. I was trying to think. There was one study that I asked her to do. It was a study of civilian nurse absenteeism.

MAJ Gurney: Oh, really? Over in Okinawa? (Laughter)

BG Dunlap: Why sure. Sure. People are people no matter where they are. Circumstances are a little different (Laughter) sometimes. But people are people. I had a large percentage of civilian nurses. Many of them were dependents. Some of our nursing assistants were Okinawans. I was concerned about a few who I felt called in sick a little too often. It was affecting the staffing. That had budget implications, and this is true any place you are. I couldn't have the civilians come back and work overtime, holidays, and so forth. So the Army Nurses had to do it. Or they had to stay on a second shift to cover. This is particularly true during the 3-to-11 shift. During the day shift we'd get a call that our 3-to-11 civilian nurse wasn't coming in on duty. So, we looked at our staffing. Where we had two nurses on, we sent one off for a few hours because she was going to come back and cover from 3 to 11.

I thought there were a few who were abusing sick leave. How could I approach this? So, I talked with the Army health nurse. I approached it out of my concern for the individual who was off sick because I realized that health care would be more difficult to get. Also, transportation to get her to health facilities would be more difficult than it would be in a stateside situation. So, I asked my Army health nurse to do a study for me on absenteeism. Then we set up a program so that she would make a home visit.

MAJ Gurney: Oh, my! (Laughter)

BG Dunlap: She made a home visit to offer her assistance to the individual who was sick. Some of them really appreciated it. They really appreciated it. It served two purposes really. It enabled some of them who were not abusing sick leave to have some assistance. They had children and maybe they needed to bring the children in to the pediatric clinic, or something. They had no transportation. Or they needed medication. They were out of medicine. Their husband might be off-island in some area, particularly the Air Force people. Because they were flying out on missions all the time. It served two purposes. When they made their home visits they helped the ones who needed help. The ones who were abusing knew that they were going to have a visit. It cut down on abuse of sick leave.

MAJ Gurney: Did she also do this for Army Nurses who may be out on quarters? Did they get a home visit also?

BG Dunlap: Did they get a home visit? They lived with three other Army Nurses in quarters. There were four Army Nurses to a quarters. So, they always had someone around to take care of him or her.

MAJ Gurney: They had to be driven to the hospital to begin with because they had to be seen to go on quarters?

BG Dunlap: I didn't have to worry about them. I didn't have to worry about the Army Nurses. Not the group we had over there at that time.

Substance Abuse

A question that really shocked me when I got back related to substance abuse. Even today, I question and talk to people about Vietnam and substance abuse among Army Nurses. I feel very safe in saying there was absolutely no drug problem among the Army Nurses. They could not have functioned the way they were required to function if they had a drug problem.

MAJ Gurney: In Okinawa?

BG Dunlap: In Okinawa. Living four to a hut, I did try to see if I could get three senior officers into a hut instead of four. So they wouldn't be quite as crowded. The

company grade officers though were four to a hut; the field grades three to a hut if possible. The fourth room could be for storage because there was very limited storage for them. We had a community storage area for trunks and footlockers and stuff like that.

But I cannot believe that I had anyone with a drug problem. Alcohol, I did have a couple that I felt drank too much. Generally not to the extent that it interfered with work, but there was one that I'm sure it kept her off duty sometimes. But usually, it was her day off. None of it came to work with them. I had a close relationship with the supervisors. They really knew their staff. They saw them frequently and they knew if anyone wasn't functioning.

But I did have a couple of Army Nurses who I felt drank more than they should drink. What can you do about it? Peer pressure is tremendous when you're living with four or three to a hut. I would try to work through the people they were living with to see if they couldn't help keep them busy or involved in something to cut down on the drinking.

When we got into that weight-control program, some of those things showed up in their blood chemistries. The two that I was concerned about were overweight. So the chief of Medicine was dealing directly with that. He and I had a lot of confidential discussions about staff. But we kept it at that level. As far as the enlisted personnel, I worked with the detachment commander. If my NCOs identified any enlisted personnel, they very closely supervised anyone they felt had a drinking problem. None of my NCOs were single and lived over in the enlisted quarters. They were all married and lived in family quarters on post. Then, we worked through the detachment commander.

Alcohol, yes. Drugs, I never was aware of any drug abuse. That doesn't say we didn't have it. But I wasn't aware of it. My supervisors were not aware of it because they would certainly have made me aware of it.

MAJ Gurney: Were there any programs over there at that time to deal with alcohol and substance abuse?

BG Dunlap: As I'm talking about it, I'm trying to think if there were. I can't think of any.

MAJ Gurney: I suspect there weren't. But I don't know.

BG Dunlap: I can't think of any. If there had been, I would have tried to get the people into that. We did have a social worker in the psychiatric service. Our psychiatric service was very small. We didn't keep patients there. They were really only in for initial diagnosis and care.

We had a category of patient over there that we had up in Alaska. They call it cabin fever. Over in Okinawa, it's rock fever. Most of those people were dependents, the wives. I've always said anyone who had cabin fever or rock fever would have it in the middle of Brooklyn but they'd call it something else. They were people who couldn't adjust to the environment that they were in.

But it was interesting in Okinawa. A few of our dependents were admitted to the psychiatric service. They went to the clubs and played the slot machines. They were slot machine addicts. This showed up because it reduced the income for the family. They were in great debt. At that time the commander was supposed to know about it. We were supposed to bring indebtedness to the attention of the commander. He was supposed to try to do something about it. He might call the individual up and do something about it.

You bet it doesn't happen today. Something about privacy rights and freedom—all those things. You can't do it any more. The commander would be sued now for doing something like that. But, in those days, it was the commander's responsibility. So the commanders discussed this with their troops. Sometimes it came out that their wives were spending excessively at the slot machines. Of course, we did have some alcoholism among the dependents because of the same type of thing.

These people came in to our psychiatric service. They eventually received outpatient counseling through the psychiatric service. If it were something that was so severe that it really was a psychiatric condition or psychotic condition, they would be evacuated. We did not keep that type of patient in our hospital.

MAJ Gurney: Did you get psychiatric casualties from Vietnam?

BG Dunlap: I'm trying to think. If so, it would only have been on an RON status. Because we were not a psychiatric treatment center.

MAJ Gurney: They may have gone to another area—probably in Da Nang—where they specialized in psychiatric care.

BG Dunlap: Or they might have sent them on to Japan. Japan was where they set up the big medical center with all the general hospitals. I can't think of any. There certainly may have been some. What we had was mostly from the troops on the island.

MAJ Gurney: What would you say was the ratio of battle wounded to non-battle wounded in the casualties that you saw?

Ratio of Battle to Non-Battle Injury

BG Dunlap: Most of them were medical. We saw patients with malaria, hepatitis, dermatitis, gastrointestinal complaints. We saw many of that kind of thing. Our battle casualties were mostly orthopedic problems. There were some chest cases. But those cases were going to be evacuated to the States. Most of them, amputees and things like that, knew they were not going to be returned to duty. We might have them RON. If their condition was such that they couldn't go right back to the States they'd stay with us. In the beginning we got that type of patient. But, as it went on and the hospitals were established in Japan, they would overfly us and go to Japan.

They would be air-evac'd for a longer period of treatment. In Japan, they set up the burn unit. But before they had that we were getting some of the burn patients. We weren't to provide long-term burn care. It was only until the patient could be moved to the States to the burn unit here.



Lt. Col. Lillian Dunlap with some of her senior supervisory staff, Okinawa, 1965 [Personal photo]; below, Colonel Dunlap, right, with, left to right, soloist Mary Heffner, organist T. Sgt. Howard W. Alsbaugh, and Chaplain Garriety after Easter Sunrise Services atop the U.S. Army Hospital, Okinawa, 1966. [U.S. Army photo]





*Viewing the Gemini space capsule, Okinawa, 1966 [Personal photo];
below, Col. Mildred Irene Clark, front row, center, Chief, Army Nurse
Corps, with senior leaders. Lt. Col. Lillian Dunlap, second row, fifth from
right, is Chief, Army Nurse Corps Assignment Branch, 1966.
[U.S. Army photo]*





Brig. Gen. Anna Mae Hays, fourth from left, Chief, Army Nurse Corps, with senior leaders of the Army Nurse Corps. Colonel Dunlap, second row, fifth from right, is Chief Nurse, First U.S. Army [U.S. Army photo]; below, with Maj. Grace McKool, visiting hospitalized children at Fort Dix. [Personal photo]





Lt. Gen. Jonathan O. Seaman, left, First Army Commander, and Col. W. W. Hiehle, First Army Surgeon, promote Lillian Dunlap to Colonel, December 1969; left, Colonel Dunlap stole away from Walter Reed to have this official photograph taken secretly because the announcement of her selection to become the Chief, Army Nurse Corps, had not yet been made. [U.S. Army photos]



Ira Dunlap proudly greets his daughter at the official retirement gala for the outgoing Chief of the Army Nurse Corps, Brig. Gen. Anna Mae Hays, and incoming Chief, soon-to-be Brig. Gen. Lillian Dunlap, August 1971. [Personal photo]

The Era of Senior Leadership

Chief, Army Nurse Corps Assignment Branch

MAJ Gurney: We're entering a discussion of your time in the position of chief of the ANC Assignment Branch at OTSG.

BG Dunlap: Yes. I received orders to come back from Okinawa earlier than the typical 18 months. I took thirty days' leave here in San Antonio with my family. Then I drove with a friend of mine, H.R. (Hattie) Brantley to Washington, D.C. Because I left Okinawa so rapidly, I didn't have time to put my car aboard a ship to ship it back. So, my NCO bought my car. I ordered a car to be delivered in Washington.

The Army Nurse Corps takes care of its own. Colonel Pat Murphy had a friend who was a WAC officer attending Command and General Staff College. She invited me to stay in her apartment until I had my own place, so when I reported I immediately had a place to stay. Pat Murphy was working with the MUST [Medical Unit Self-Contained Transportable] Study Team and was traveling a good deal. She said I could use her car because she didn't use it anyway. So, I had a car and a place to stay, which is always a chore to anyone reporting into Washington, particularly for the first time and unfamiliar with the area.

At that time my good friend [Lieutenant Colonel] Edith Bonnet was working in The Surgeon General's Office. She was the nurse methods analyst. She saw to it that I went around to all the different apartments. I finally found an apartment in Arlington. This really was an extension of the Army Nurse Corps Branch, I think, because so many of us lived in that apartment area. There were about five apartments in that area. The assistant chief of the Corps, Colonel Gladys Johnson; Ski Straley [Rose V.]; Aloha Hammerly, the community health nurse; Edith Bonnet, the NMA; and Pat Murphy; several WAC officers; and Kathy Leath, a physical therapist who worked in AMSC Branch. All of us lived in that area, which helped. When you go into a strange area and especially an area like Washington, D.C. It made the adjustment easier.

The Surgeon General's Office was in the old Main Navy Building which was considered "temporary quarters." It had probably been "temporary" since World War I. This was the biggest disillusionment to me. I walked into The Surgeon General's Office and saw what a dump we were going to be working in. I had just left Okinawa with a beautiful office and a new hospital. It was a blow to walk into The Surgeon General's Office in this old beat-up place. I had more space for my office in Okinawa than we had for the four Army Nurse Corps officers assigned to The Surgeon General's Office in the branch.

It was the physical facility that was disappointing. The reception by personnel was entirely different. It was a very warm and welcome reception. I didn't know just what my duties would be as the chief of the Army Nurse Corps Assignment Branch. Gladys Johnson, who had been the chief, had moved up to become the assistant chief of the Corps. She was certainly of great assistance to me. Lieutenant Colonel Ski Straley, who had been the assistant chief of Branch, was still there. Ski, of course, was of great assistance to me. [Major] Jean Barcus and [Major] Anna Antonicci were assigned there. They all taught me what my job was to be. And we had fun doing it. The secretary, Hazel Rhodes, had been with the Army Nurse Corps for about fifteen years by that time. Her specialty was the MOS [military occupational specialty] review. She knew the MOS of every Army Nurse in the Army Nurse Corps, I think. And although retired, could probably today tell you what they were at that time. I moved into a very warm and welcome environment.

STAFFING THE ARMY NURSE CORPS DURING VIETNAM

But just what would be the duties of the chief of the Army Nurse Corps Assignment Branch? Vietnam was ongoing. That was the big problem, staffing. At the height of Vietnam we had 900 nurses over there at one time. It was a one-year tour. So this meant that we were constantly looking for the replacement for the replacement that was to go to Vietnam. This process was unending in order to keep Vietnam staffed. Fortunately, the Army Nurses volunteered to go to Vietnam. There were very few exceptions to that. It was only toward the end of Vietnam that we had to put people on assignment to Vietnam who might not want to go over there as their first choice. It was interesting to me that when we put people on orders to go up to Korea, they'd come in and ask, "Can't I go to Vietnam instead of Korea?" Because they wanted to be where the action was. Some in OR and anesthesia, I think, served a second tour in Vietnam. Those were the two MOS's that were our most critical shortage. It was also interesting to me that Army health nurses wanted to go. We did not have positions for Army health nurses in our field units. I'm sure that they could've done a tremendous job working in the community in some of the assistance programs. But you don't staff your wartime hospital units with Army health nurses. So, I had many Army health nurses just cry on my shoulders because they couldn't go to Vietnam. They had to fill the vacancies in CONUS.

MAJ Gurney: What about the specialty nurses? For instance, the OB/GYN or pediatric nurses? If they wanted to go to Vietnam what would happen?

BG Dunlap: If they wanted to go to Vietnam, it depended on our shortage in CONUS at that particular time. I can't tell you how many went. Some did go, I'm sure. But we primarily were looking for OR, anesthesia, and med-surg [medical-surgical] nurses for Vietnam.

MAJ Gurney: Were they encouraged to change their MOS and then they could go?

BG Dunlap: They weren't encouraged to do it because we'd just be creating a shortage in the original MOS. We were trying to fill all the MOS shortages. But some of them certainly wanted to go. Some of them did get to go.

I went into the position of chief of the ANC Assignment Branch in September of '66 and stayed until the beginning of '68.

ORGANIZATION OF THE ANC ASSIGNMENT BRANCH

MAJ Gurney: Before we get into specific issues, can you describe for me the organization of the ANC Branch at that time?

BG Dunlap: We had four Army Nurse Corps officers. The chief of the branch passed on all chief nurse and key assignments. Assignment responsibility was distributed by MOS. The assistant chief of the branch was assigned to chief nurse and key assignments. She identified the people for these roles and presented them to me for approval. The other two officers divided their duties up by MOS. I know anesthesia and OR came under one nurse and med-surg nurses came under the other. They tried to make the officers' assignments they were responsible for as equal as possible.

That was the branch, plus we had one secretary, who was in the section where the chief was, Hazel Rhodes. She worked on MOS's and prefixes. When she reviewed these, she presented it to the officer of that particular MOS for recommendations for change. We had three other civilians in clerical positions.

That was the Army Nurse Corps Assignment Branch. It carried quite a workload. Not only just managing the careers of those individuals and assignments, but it responded to many other demands placed on us at that time. One of those was answering the congressionals. That hasn't changed, I know. This was a rude awakening to me. I was beginning to learn how to function at that level. Many congressionals that came down to The Surgeon General were then staffed to the action branch. Those that came to the Army Nurse Corps most often pertained to an Army Nurse about her assignment. Anything about an Army Nurse that came down, came to me at the Branch. I'd have to prepare a response to take back to the director of Personnel, who would take it back to the Deputy Surgeon General for The Surgeon General's signature. Searching out the facts to prepare the response, preparing the response to comply with the SOPs [Standard Operating Procedures], and preparing the final correspondence was a chore. The process varied constantly depending on which agency sent it down.

I'll give you an example. The Surgeon General had a request from Sargent Shriver who was heading up the Peace Corps. He wanted to start a program in the Washington area for training of some of our minority people in the health-related areas. It came down through channels that they wanted an Army Nurse assigned to that area. We didn't want to give him one. But we had to. Preparing the correspondence to go back to him to say who was nominated to fill that space took at least two weeks. We prepared it according to the way The Surgeon General's secretary said it should be prepared. It went up to her. Then, she coordinated it with the next person

to send it to because this was an unusual situation. But it was wrong. It had to come back. It took us two weeks to prepare the correspondence for The Surgeon General to put his signature on it although the decision had been made much earlier about who the individual would be. You can imagine how frustrating that was to me.

Also, we didn't have computers in those days. We didn't have personnel on computer runs. We were constantly being asked, and I'm going to be facetious here: "How many Army Nurses do you have who have six fingers on their right hand?" "How many nurses have been in service a certain length of time?" "How many nurses are graduates of certain programs?" "How many nurses this or that?" "How many nurses have spent so many years in service before being sent to Vietnam?" There was absolutely no way that we could go talk to the computer to get the information because we didn't have that information then to have a printout. We had what we call "Linus' Blanket." That was a printout of the personnel roster. I can still see Ski Straley, Gladys Johnson, and myself taking those printouts home at night, grabbing a bite to eat, putting on our green eyeshades, and getting out our quill pens to go through those rosters counting off the individual names to come up with the statistics to answer a congressional query or a DoD query. When I think about what can be done with computers today, I just think my time was too early. The whole Surgeon General's Office faced this in responding to inquiries and to the many, many demands that were placed on us at that time.

PROFESSIONAL DEVELOPMENT

Another area of concern was education. We had developed certain MOS-producing courses for Army Nurses. We wanted to increase recruiting into those courses. That was how we produced our specialists. We weren't recruiting directly to get OB/GYN nurses or other specialists. They weren't coming in to those specialties like that. We were trying to produce as many as we could out of our own MOS-producing courses. We had to really push our chief nurses to encourage nurses to apply for the courses. But they didn't want to lose the nurses they had on their staff to go to school. We wouldn't promise they'd come back to them. We could get replacements in for them but there might be a time lag there before some of the replacements got in.

In connection with that, then, we were concerned at the same time because we were staffing for a wartime situation. We needed to have nurses prepared at the undergraduate and the graduate level. We had to justify long-term civilian training. We had the bootstrap program—people went to school on their off-duty time—but we wanted to justify full-time, long-term civilian training. They set up what they called the GER—the General Educational Requirement Board. The Army set it up. The Surgeon General, or his representative, had to appear before the board to justify the requirements for graduate education for AMEDD personnel.

Justifying Graduate Education

We in the Army Nurse Corps Assignment Branch had to prepare the Army Nurse justification. To do this we had to determine how many spaces required

Army Nurses with master's preparation or higher. That was not an easy chore. At the same time, we were still justifying undergraduate education too. But we particularly had to justify graduate study. For instance, many people couldn't see why the chief nurse needed to have graduate preparation. She was a nurse; in their mind that was all she needed.

We prepared our portion of the information. A nurse from the ANC Branch would always go over with the director of Personnel and Education and Training or whoever was designated to appear before the Army's board to justify for the AMEDD. We sent a nurse over from our branch to back up whoever was presenting it for The Surgeon General.

MAJ Gurney: How did you decide what positions justified that graduate preparation?

BG Dunlap: We threw darts at a board.

MAJ Gurney: Oh, yeah? (Laughter)

BG Dunlap: That's the way we made assignments. We threw darts at the board. (Laughter)

No. We had to think in terms of what positions in nursing required it. What are the top positions—the leadership positions—in nursing? What is the organizational relationship of that individual with the rest of the staff? Take for example the chief nurse. She is the chief nurse and has responsibility for all nursing services at the executive level. Her organizational relationship is with other department heads. What educational level are they prepared at? If she's going to assume as much or more responsibility than they have, she certainly needs an equal or greater educational preparation than they have.

We also looked in terms of the profession of nursing. What are our nurses prepared at the graduate level prepared to do? If you look at the big civilian medical centers and teaching centers, certainly those directors of nursing are prepared at the graduate level. Should we have less in the Army? No. We should have equal or better with the responsibilities we expect from our leaders.

So, we took these things into consideration. We left specific people out of the equation. We just looked at positions. We did that at all levels in the Nurse Corps beginning with the Chief of the Army Nurse Corps and staff positions in The Surgeon General's Office and at army headquarters. At that time we still had Army Areas, and chief nurses at Army Areas. We had WRAIN [Walter Reed Army Institute of Nursing]. There was no question about that. The University of Maryland required faculty to be master's prepared. We went to our medical centers and looked at the positions just as I indicated to you. We looked at the Medical Field Service School and the educational programs that we had and what the educational preparation should be for those. We looked at both the directors of those programs and the staff. As we looked at each position in the organization of nursing service, we attempted to identify those that we felt should have doctor-

al preparation versus master's preparation. Even then, I believed very strongly that we should all be prepared at the baccalaureate level as a minimum.

Based on that then, we recommended the educational structure for the Corps. We were very fortunate to receive as many spaces as we did. But that was only one part of the equation because when it became a recognized space for graduate preparation, that didn't mean we had funds to send someone to get the education. But that was the beginning.

MAJ Gurney: This is in 1966. Where were the Ph.D. validated positions most likely to be found at that time?

BG Dunlap: The director of WRAIN and the director of Nursing at what is now the Academy of Health Sciences. The Chief of the Army Nurse Corps was another validated position. I'm trying to think if those were the top three positions we had at that time.

MAJ Gurney: The Walter Reed Army Institute of Research [WRAIR]?

BG Dunlap: Probably. Probably.

MAJ Gurney: One or two positions?

BG Dunlap: Probably one at the time, the director.

Of course, we didn't have many people going for doctoral study at that time. There was always controversy about whether the Chief of the Army Nurse Corps should be prepared at that level. They felt that she didn't need all that education.

MAJ Gurney: Who felt that?

BG Dunlap: Some of the people in the Army.

MAJ Gurney: Nurses? Or other than nurses?

BG Dunlap: Other than AMEDD.

MAJ Gurney: Like the line? Why?

BG Dunlap: Why did we need that preparation? We're nurses. (Laughter)

MAJ Gurney: How did you respond?

BG Dunlap: We're officers. But let's recognize that we were faced with another side of that coin. We had commissioned officers who had less than baccalaureate degrees. These officers were serving as majors and lieutenant colonels. It

was always very hard for me to justify a program to bring the Army Nurse Corps officer up to equal opportunities when we had graduates with less than a baccalaureate degree. All the other officers in the Army had a minimum preparation of the baccalaureate degree. Why should we let Army Nurses with a baccalaureate degree come on active duty as a first lieutenant instead of a second lieutenant? And those with less than a degree come in as a second lieutenant? We did that at that time. Why should our nurse who just has a baccalaureate degree come in as a first lieutenant while an MSC who has a doctorate in psychology might have to come in as a first lieutenant. There were some very good arguments against us.

We had the support. Colonel [Roy E.] Clausen, Jr., was the director of Personnel and Training. Colonel [William H.] Meroney was deputy chief of Personnel. He later was [Brigadier] General Meroney and commanded Walter Reed when I got there. They backed us in nursing.

MAJ Gurney: Besides having their support, what did you do to overcome that opposition? You must've used some arguments of some type to justify it.

BG Dunlap: We tried to point out they were officers in areas of significant responsibility. If possible we compared them to persons of less responsibility, highlighting the contrast. We tried to be logical. This is the thing I've always said in dealing with men, you have to be logical. You have to talk statistics and not emotions. Because men understand statistics. Some of them understand logic. Particularly when you're talking about senior officers in the military who have been trained that way.

We began to open the doors to get more sent for graduate education. Then it came down to funds. After we'd gotten all those school spaces—recognized requirements for them—then there was never enough money to send people. Nor could we actually spare that many people from nursing duties to go to school. Certainly not to go for full-time study. Later, the funds were sent down to The Surgeon General's Office for graduate training. The distribution was made by The Surgeon General's Office to the Corps. Each Corps would get a certain number of spaces. The funds weren't sent down by space. The Surgeon General received a certain amount of money. He would work through Personnel and Training to come up with how much of it would go to the MSC, MC, ANC, and so forth by Corps. Once we found out how many we could send, then we had to identify the people.

We encouraged applications, got the word out to get the completed application for graduate study in on time. In the meantime, we'd start looking for a replacement for the individual that we were going to be sending to school for graduate study. It was a continuous cycle of justification, identifying the people, getting them processed, selecting them, and getting them on into school.

MAJ Gurney: Was there a section of the branch that focused on long-term civilian training and the professional short courses?

BG Dunlap: We had that in our branch. Our officers handled that. Enlisted training was done differently. We had an Army Nurse working the 91 Charlie issues, but that was done differently.

MAJ Gurney: I'm sorting this out because I know that there are two additional people that do that now.

BG Dunlap: That was at the beginning when I was in the branch. It was different when I came back as Chief of the Corps just a little later. We reorganized it. But this is way back in the 60s. This is the brown-shoe Army. (Laughter)

We were able to justify recognized requirements for graduate education. We got some funds and got some people into the programs to prepare for leadership positions in the Army Nurse Corps.

MOS REVIEW

Another big area of work was the review of MOS's. By regulation, we're supposed to review each officer's MOS periodically. We could not get through to the individual Army Nurses that it was their responsibility to look at their MOS and their 201 Files to see if in fact they were functioning in the MOS, or to determine if they were qualified for the MOS they were functioning in. It was the individual's responsibility. Then they were to notify us when they were interested in a change of MOS. If they did qualify for a change in MOS, then they needed to get the request for the change to The Surgeon General's Office so we could review them. We found that we had to initiate the action at our end instead of the way it was intended. We did have the one civilian secretary who reviewed every request for change of MOS that came in. She determined if in fact they met the minimum requirements for it. Then she would give it to the officer who managed that particular MOS. It would be awarded if the individual was qualified and then sent back down to them.

I was concerned about the A prefix. Until that time, we only had three Army Nurses who had the A prefix. Sally Travers in the operating room, Mercedes Fisher in Army health nursing, and Ruth Satterfield in anesthesia all had the A prefix.

MAJ Gurney: This is The Surgeon General's A prefix?

BG Dunlap: Yes, it's awarded to the top people qualified in the different MOS's. Every time we had a staff meeting they announced the new Prefix As. I would hear other Corps, but not the Army Nurse Corps. The number they had was greater than ours. It really, really concerned me. I said we must make a review of the Army Nurses and determine those who qualified for Prefix A or were near qualification for Prefix A. I would let them know that they need to go work in this area, or do this or that to qualify for the Prefix A. We started really working on it at that time. I can't tell you the number now. I'm sorry. It completely slips my mind.

SPECIAL ASSISTANT TO THE CHIEF, ARMY NURSE CORPS

We were able to have additional Prefix A's awarded to a number of our Army Nurses. I'm thinking in terms of something like maybe ten more highly qualified Army Nurses. If I called Hazel Rhodes in Arkansas, she could tell me who they were.

MAJ Gurney: How was it that you were able to achieve this? What did you do?

BG Dunlap: We did it by identifying the persons qualified, and pushing them to prepare for it, and presenting it to The Surgeon General's Board for award.

MAJ Gurney: You actively got into the business of presenting the qualified individuals?

BG Dunlap: We prepared the records of the qualified individuals for the board.

MAJ Gurney: Had that been done before? Did the ANC present the records of the others who qualified?

BG Dunlap: Yes. Each Corps was responsible for identifying and recommending the ones who should be awarded this honor. That really was a big morale booster for senior members of our Corps. We could then read in the post paper or the hospital paper that a Surgeon General's A prefix have been awarded to Dr. so-and-so, and so-and-so, and so-and-so. To have a nurse among the group really was a big morale booster.

WARRANT OFFICER PROGRAM

At this time there was a big conflict about the warrant officer program. I've indicated to you off tape that I've had difficulty separating what happened when I was chief of the Branch and Chief of the Army Nurse Corps. I was involved in so many of these programs. But this I'm sure was when I was in the branch.

MAJ Gurney: That was 1966 for the warrant officer program?

BG Dunlap: This had been initiated before I came into the branch. We were beginning to get some of the flack from it.

MAJ Gurney: What was the flack?

BG Dunlap: It was very similar to what was happening in civilian life. Associate degree RNs took the state board exams and passed the same state boards as three-year graduates and collegiate graduates. They were RNs. Why did they have to come on duty in the Army as a warrant officer rather than a commissioned officer? In reality, when they were put in their staff assignment in their hospital situ-

ation, because they were RNs, they really functioned as RNs. In medical centers where there was more staffing there were more layers of supervision. But when we assigned them to small facilities where there was not that much supervision, they were functioning as RNs and doing a good job—most of them. They resented being a warrant officer and not having full officer status.

MAJ Gurney: You mentioned that you got flack in terms of the warrant officer program from the warrant officers themselves who wanted to be officers. What was the attitude of the nurses who were commissioned officers about the warrant officers?

BG Dunlap: I think it depended on the individual warrant officer; many of them were outstanding nurses. If they were on a staff the chief nurse certainly supported them. Many questioned why they had to be warrant officers although they were AD graduates and not baccalaureate degree graduates. In our Corps, there was still a lot of hesitation on the part of some of the Army Nurses to say that everyone should have at least a baccalaureate degree. They were nurses with many years' experience, and many would say they were just as good a nurse as some of those whippersnappers coming out of college. They said that a college degree wasn't going to make them a better nurse. I'm just saying some of the things that we kept hearing. We heard this among the physicians, too, and other members. This was particularly apparent when we had a warrant officer who was doing as good or better job than a graduate of diploma or a collegiate program. We were constantly getting arguments on that.

Then, the professional organization weighed in on the issue. These warrant officers would go to the professional organization and question why they should not have full officer status as members of the Army Nurse Corps when AD graduates in the civilian life were fulfilling the same types of positions as graduates of the hospital schools and the collegiate programs. Remember, we had many more hospital schools of nursing then.

MAJ Gurney: What was the response of the professional organization to that?

BG Dunlap: They had questions in their own minds. We still have that problem in professional nursing today. The professional organization has determined the minimal educational requirement for a professional RN should be a baccalaureate degree in nursing. That's still not accepted by all of the profession as a whole.

MAJ Gurney: Wouldn't the Army Nurse Corps have gotten the support of the ANA [American Nurses' Association] because by 1966 hadn't the position paper come out?

BG Dunlap: The position paper had come out in 1960. That didn't mean that they were pushing it that much. It was wartime.

MAJ Gurney: Do you feel that the Army Nurse Corps didn't necessarily get the support of the ANA and the NLN related to the warrant officer program?

BG Dunlap: I'd hate to make that statement. I really would. Remember, there were some real nursing leaders who set up the AD programs. They were respected in the nursing profession. There was a big question in the nursing profession about the utilization of AD graduates. That was an area of our concern.

When did we show in our history that the warrant officer program was discontinued?

MAJ Gurney: 1968? In October 1976 a bachelor's degree was required for accession to active duty.

BG Dunlap: [Colonel] Marge Wilson had been involved in the implementation of this program. Then she came back to The Surgeon General's Office, I think. Or Jeanne Treacy was anyway. Jeanne Treacy followed me as chief of the Army Nurse Corps [Assignment] Branch. She had been in the branch before when this study was done. It was discontinued after I left. I left the first of '68. I can't get into the final action other than it was discontinued.

ORIENTATION TOUR PRIOR TO DEPLOYMENT

One of the programs that we initiated was providing orientation tours for nurses going to Vietnam. We had large numbers of volunteers. They finished basic training. If they volunteered to come on duty with a guaranteed assignment to Vietnam, they shouldn't have been sent straight to Vietnam. Some of them were, in the beginning. We felt that those who had guaranteed assignments to Vietnam should first go to one of our hospitals and have an orientation tour there. I can remember sending some up to Fort Knox. Those who had guaranteed assignments to Vietnam were sent to a hospital here in CONUS for a few months' orientation prior to going to Vietnam.

We had to justify the expense, because that was significant added expense. Two PCS's within one year, but one PCS was an overseas tour. We could justify it that way. We felt it was very essential that we do this.

I want to make a point related to Vietnam and staffing. The Army Nurse Corps was commended by [Lieutenant] General [Leonard] Heaton [The Surgeon General] after he made a tour to Vietnam. He came back and commended the Army Nurse Corps for assigning their best-prepared nurses as chief nurses. This wasn't true of some of the other Corps. The Medical Corps was one of them. He commented on that and put it on the record. Some Corps did not necessarily send the best-prepared people to Vietnam. He really found that we sent our best people to be chief nurses in Vietnam. Our senior people were the officers best prepared to do it.

I think that's one reason we had as few problems as we did. We did have some problems. One particular hospital I know had big problems during this period of

time. That was taken care of with replacement of personnel. We really tried to send our most qualified people over to Vietnam.

Normally, we thought of a tour in The Surgeon General's Office as three to four years usually. I was brought in from a curtailed assignment in Okinawa to get me there. I did not know at that time that the position of the chief of the Army Nurse Corps Assignment Branch had been recognized as a full colonel position. I had served in it from the rest of '66 and all of '67. A promotion board came up for full colonel. I was in the zone of consideration. People in The Surgeon General's Office, not just Army Nurses, but other Corps thought—remember, I'd taught at MFSS, and been involved in the hospital administration program. I had many friends in the MSC and other Corps. They all thought when I was brought in that that meant I was going to be promoted to full colonel.

The promotion board was held. Fifteen Army Nurses were selected for full colonel. I was not selected. We had a wake in my office that lasted for weeks. (Laughter) People kept coming in to tell me they couldn't understand it. It was like a wake, really. I was so naive and dumb. I didn't even know I was filling the full colonel position. Then, when the promotion board came up and this happened, the outpouring of sympathy was something. They just couldn't understand why I didn't receive my eagle. The Chief of the Army Nurse Corps was Colonel Mildred Irene Clark. She came down and sat by my desk (whispering). "She talks in a whisper like that all the time". (Laughter) She said that she wanted to explain to me why I didn't get it. She felt that Colonel [Marion] Tierney, who was the chief nurse in Vietnam, should have it although she was junior to me. And she certainly did not have the positions that I had had. But, since we only had one nurse in a combat zone, she should get an eagle. There were others who were senior to me and had been lieutenant colonels much longer and that was not the concern. But Marion Tierney got it because she was in the combat zone. That hurt, but not that much. What happened next is what hurt.

Because Colonel Clark finished her tour as Chief of the Corps and Colonel [Anna Mae] Hays finished her master's degree at Catholic University, she came back as Chief of the Army Nurse Corps. She had been in awhile. She came down and talked to me and told me that I was going to be reassigned since I hadn't been selected for full colonel and was filling a full colonel position. I said it didn't make any difference to me. I didn't think it was making any difference as far as my performance. I wasn't encountering any difficulty dealing with full colonel chief nurses anywhere. I couldn't really understand why, just because I hadn't been selected for full colonel, I would have to be moved. I had filled the position before and wasn't a full colonel, why did I have to be moved? She was going to bring Jeanne Treacy in as chief of the branch because she was a full colonel. She had been in the branch before, but not as chief. She'd bring her back in as chief of the Army Nurse Corps [Assignment] Branch. She wondered where I wanted to go.

I was stubborn at this point. Maybe she would send me here or there. At this point we had the nurse position in Dr. Wilburn's office in DoD. It was occupied by [Captain] Alene Duerk who later became the Chief of the Navy Nurse Corps. I said I wanted that position because it was about time for a change. The Army

Nurse Corps staffed the idea forward but DoD said “no.” They were rotating it and it was time for an Air Force Nurse to have it. So, I couldn’t have that position. I said I wanted to go over as chief nurse of First Army. At that time the chief nurse of First Army was being reassigned. I knew these things. I was in charge of assignments for those people. I told them I would like to have the position as chief nurse of First Army. She wasn’t so sure I should have that position. I really think she didn’t want me that year. (Laughter)

MAJ Gurney: Oh, dear.

BG Dunlap: What I’m going to discuss is personal, but this was a very, very difficult period for me. I had to continue to function as I was trying to cope with the feelings. I never encountered anything like that. My experience had been that I was always pushed ahead. Even most recently when I had been put in a colonel’s position as a lieutenant colonel.

Colonel Hays still hadn’t decided what she was going to do with me. It was time for Gladys Johnson to be promoted to full colonel. She was going to Walter Reed to be chief nurse there. Anna Mae [Hays] decided that I would come up into her office as special assistant to the Chief of the Army Nurse Corps until she could decide where she was going to send me. So, I went up. I had an office. Well, I had a desk in the outer section where, at that time in the old Main Navy Building, the assistant chief sat right outside the door of the Chief. The two secretaries sat out there. And I had a desk out there. That’s when I finished up the work on the Prefix A. I got that through during that period of time.

I shall never forget the day. It just happened to be the anniversary of the day that I came into the Army Nurse Corps, November the 16th. The ANC Chief held a monthly meeting with the nurses in the Washington area. At that time it was announced that we were celebrating Gladys’ promotion and at the same time announced that I would be leaving, as chief of the Army Nurse Corps Assignment Branch and Jeanne Treacy would be replacing me. It also was clear that they hadn’t decided my assignment yet. But I’d be moving in as the special assistant in the Chief’s office. Then we went after that to lunch to celebrate Gladys’ promotion. Now, talk about ego deflating!

MAJ Gurney: It must have been devastating.

BG Dunlap: I was crushed, and to announce it like that. I thought they should have waited until they decided what my position would be before they announced it. I felt this openly linked my departure to the fact I wasn’t promoted. It turned out it was the best thing that ever happened to me. How can I complain now? (Laughter) It’s true. When a door is closed, a window opens.

MAJ Gurney: Sometimes, these humbling experiences really just help fill out the individual.

BG Dunlap: Very few people know this happened. The people right there working with me knew it. Others outside that group would never know it because lists weren't published. General Hays never said anything about it to me. I wanted to share it with you because you still have a good portion of your career left. I want you to know that it isn't all a bed of roses to the top.

MAJ Gurney: Oh, I know. (Laughter)

BG Dunlap: Things happen. I mean it.

MAJ Gurney: Yes. I've had those experiences and I'm sure there will be more.

BG Dunlap: I'm serious, because at that point I had 26 years of service. I could retire with no problem. I had not thought of retirement. I was stubborn enough, I was going to win that battle and get assigned where I wanted to be assigned, and just to show them they were going to have to put up with me. I was having a great career. I did not want to get out of the Army at that time.

Then it was finally decided that I could go to First Army as chief nurse. So, as a lieutenant colonel, I went out to First Army headquarters at Fort Meade, Maryland, as chief nurse of First Army.

Chief Nurse, First Army

I was in the assignment at First Army three years, then at Walter Reed for four months. I have the distinction of having the shortest tour as a chief nurse at Walter Reed. (Laughter)

Most people homestead. I stayed four months. I said they believed in Peter's Principle and kicked me upstairs to get rid of me there.

MAJ Gurney: Is there anything else up to this point leading into your assignment to First Army that we need to go back to? Or, anything that has not been covered well?

BG Dunlap: Not that I can think of right now. Really, no.

MAJ Gurney: Did you go into First Army with any goals? Did you have any plans, or things that you wanted to do with this position?

BG Dunlap: I went into First Army from The Surgeon General's Office. I had been chief of the Assignment Branch. As such, I was very much aware of the staffing requirements in First Army Area. I had some feelings about utilization of nurses in the different hospitals based on my position where I had to provide the nurses to meet their staffing requirements. Also, with Vietnam going on, we had constant demand to replace the 900 nurses over in Vietnam. We had to pull from those hospitals in First Army to send those replacements. I was truly aware of

staffing shortages that I had created by having to take the nurses out and not being able to provide timely replacements. We created an underlap.

I knew I faced this from the other side of the coin now. This would be happening to me. I also knew the importance of the relationship between the chief of the Assignment Branch and me as chief nurse of First Army. We had to be able to have a one-on-one relationship to discuss staffing because staffing was a real key problem in the Army Nurse Corps at that time because of Vietnam. So, that was one thing that I was concerned about.

I had experienced my first taste of an Army Area as a captain at Fourth Army headquarters from 1950 to '53. I had observed how a headquarters operated at that time. I also was aware that there had been many changes in the Army Area headquarters—in the Office of the Surgeon. I really wanted to identify what the role of the chief nurse of the Army Area was. I, as chief of the Assignment Branch, had depended on the chief nurses of the Army Areas a great deal. I feel very strongly about chain of command. Although the chief nurse of the Army Area did not have command *per se* over nursing services—maybe we should say “chain.” But it wasn’t even chain of authority. It was an organizational relationship. I felt that the chief nurses of the individual hospitals should go through the chief nurse of the Army Area who then would come to the Chief of the Army Nurse Corps or to the chief of the Assignment Branch about assignments. This was not always done. Frequently it was based on informal relationships. I had some apprehension about making it work and seeing if it was feasible. I felt that as chief nurse of the Army Area, the chief nurses of the hospital should be able to come to me. If it was something that could be worked out at the Army Area level, we should try to do it. If not, then I should go to The Surgeon General’s Office to see if something could be worked out rather than having the individual nurse or the chief nurse of the hospital going directly to the chief of the Assignment Branch with something.

MAJ Gurney: During the time that you were at Career Activities, was this the practice? Or was this not done in this way?

BG Dunlap: This was something that I tried to keep under control but it was not always done. Some chief nurses of hospitals within the Army Areas wanted to come directly to the Assignment Branch. The question had to be “Has this been discussed with your chief of the Army Area?” You can’t tell them, “Don’t call me,” because, then, they feel that you are not interested in their problems. Was the chief nurse of the Army Area strictly a staff position? Or was it one of involvement? So, I went to that headquarters thinking, now I would have to find out what’s really going on in headquarters. What’s expected of me? Just like when you go into any other job. What is expected of me? So, that’s the way I entered it.

MAJ Gurney: Were you successful in working out that issue of chain of authority, or chain of command among the facility chief nurses, Area chief nurse, and the Army Nurse Corps Assignment Branch?

BG Dunlap: I felt I was successful. I'm not so naive to think that it was totally successful. But I felt that it was usually successful. One reason I felt it worked was that shortly after I went there, Colonel [Charles] Pixley came in to become the Surgeon at First Army. He later became [a lieutenant general] The Surgeon General. Colonel Pixley depended on me as chief nurse of First Army for information related to what was going on in nursing in the hospitals—not just nursing in the First Army. Each morning when we met, or if he had any particular concern about a problem that we heard was going on in the hospital, he asked me if I knew anything about it. General Pixley's wife had been an Army Nurse—he had the greatest respect for Army Nurses. He knew that Army Nurses knew what was going on in the hospital twenty-four hours a day. So, he depended on me as chief nurse to know what was going on, not only in nursing service, but in the entire hospital. The Area chief nurses knew that.

I was fortunate because I had assigned most of those chief nurses to those positions. I made those assignments not knowing that I was going to be chief nurse of First Army. I don't want to imply that I put my friends in there specifically, because that was not true. But I had been responsible for their assignments out there. Then, when I got there to be the chief nurse of that Area, we already had established an organizational relationship. Remember, I had been in a pretty long time by then, so I knew many of them personally. I had been the instructor for many of them at the Medical Field Service School. They felt that they could come to me, I think. I made staff visits to the facilities. I called them periodically also, so I think they felt that they could call me about any problem they had. We tried to solve organizational problems at the Army Area level. Colonel Pixley supported that. "Organizational relationships"—that's a fancy word for you know what. And, because there are conflicts within hospitals sometimes, if they're known at a higher headquarters level actions can be taken that can help resolve them. As I said, I'm not so naive to think that I was not bypassed if a chief nurse wanted to call in to the Assignment Branch, or something like that, but I think it was reduced. I was satisfied with the organizational relationship that we had. Remember, I was there three years, 1968 to 1971.

THE MEDICAL DEPARTMENT ACTIVITY (MEDDAC) CONCEPT

MAJ Gurney: What other issues did you deal with? You mentioned to me the MEDDAC issue.

BG Dunlap: Gosh, do you have the date MEDDAC was implemented? Well, the minutes for the Chief Nurses' Conference are one place for me to look. I know they had me come in to talk about the MEDDAC because they felt that we in First Army had implemented it more extensively than any of the other Army Areas.

MAJ Gurney: Could you just briefly describe what the concept is?

BG Dunlap: All right. Prior to the MEDDAC concept, all of the medical facili-

ties came under The Surgeon General. There was no question about the medical centers. They would continue to come directly under the supervision of The Surgeon General. But there had always been conflict at the posts. We used to refer to them as station hospitals. But the conflict related to what was the post commander's authority and responsibility for the health care facilities at the posts, camps, and stations within the Army Area and on their post. Did that facility come under The Surgeon General? Or did it come under the commanding general of the post such as Fort Meade? First Army headquarters was at Fort Meade. Who did the post surgeon report to? Was it to the commander of the post? Or to The Surgeon General's Office?

In developing the MEDDAC concept they said the medical centers would continue to come under The Surgeon General. The medical facilities on a post would really have dual responsibility to the post and to The Surgeon General's Office. I'll get away from Fort Meade because they had First Army headquarters there. Consider Fort Knox, Kentucky. For professional matters they would consult with the First Army surgeon who then coordinated with the CONARC [Continental Army Command] Surgeon and with The Surgeon General. For military matters, they came under the post commander and through that chain of command. As it turned out, the post commander was evaluating our hospital commanders. Then, I think, endorsed by the Army Area Surgeon. The post commander wanted to have some authority related to the hospital. He thought of it as his hospital.

This was a difficult concept to sell along the way. We wanted to be sure that the post surgeon came under the First Army Surgeon, under the CONARC Surgeon, and on into The Surgeon General's Office. You can imagine the conflicts between line and professional people. Those conflicts are at all levels. Some of the medics didn't buy it. The line didn't buy it. It took a great deal of cooperation to make it work. Colonel Pixley worked so beautifully with our First Army commander, [Lieutenant] General Jonathan Seaman. We worked very hard in First Army to be sure that all of the health care facilities then came under the First Army. We had many industrial health clinics. These clinics were in Army arsenals and depots in rural areas of Pennsylvania, Maryland, and New York such as: New Cumberland Army Depot and Fort Ritchie. Fort Detrick didn't have hospitals. Blue Grass Army Depot was in Kentucky. Watervliet Arsenal and the Boston Navy Base were other health clinics. Wherever there was an Army depot, they had an Army health clinic. All of that came under the First Army Surgeon.

ARMY HEALTH CLINICS

This increased the responsibility of the chief nurse to provide supervision of health care given in those areas in addition to the hospitals. We had some wonderful experiences. They resisted in these health clinics. They were staffed by civilian nurses and usually by civilian doctors who'd been there for a long, long time. In my opinion they were not doing occupational health nursing which is what they were supposed to be doing. Some were. But not to the degree that I felt they should. At

Aberdeen Proving Ground, we not only had a hospital but we had the Army's Environmental Hygiene Agency. There was a civilian nurse assigned up there. I used to be invited to go there to speak when they had courses about the role of the occupational health nurse in Army facilities. We got our Army health nurses, now Army community health nurses, involved in those programs. I felt that in a number of the clinics the nurses were acting as first-aid nurses and not truly getting involved in developing programs for the employees such as safety, prevention of sickness and illness. A lot of them were limited in their assignments based on their location. For instance the safety officer might consider that in his realm, and he didn't want them involved in the safety programs. But I felt that they should work with the safety officer to prevent injury at their site. They should see that the employees were aware of the potential hazards in their work. Were there programs developed for the prevention and treatment of any injuries there? Were they prepared to evacuate patients who required further hospitalization? They should be involved in planning for it, not just content with having a document handed to them.

This was what they were supposed to do if anything happened, not just to run a first-aid clinic to wash out an eye, put a patch on it, or bandage a cut. This was a challenge to those nurses who'd been in the jobs for many years. They resisted it. They were happy when I left their post. But they didn't realize I was going to be coming back, which I did. I served three years there. So they had to put up with me for three years.

On the other hand, there were some who really responded well to this. They really developed programs there. But if they had civilian physicians who'd been there many years and didn't really develop occupational health programs, how can you expect the nurse to do it if she couldn't motivate that physician to do it. Some did poke them and get them going and really take the leadership role in developing programs. At some of the places, particularly Ritchie, we had health education personnel assigned to run their clinic.

I shall never forget one trip I made up there for a staff visit. I was checking the dressing cart, the thermometer trays. The word must have gotten around. You know how the underground is. They were alerted that I would check thermometer trays. We were using Wescodyne to sterilize thermometers. The corpsman proudly showed me as he took the lid off of the thermometer tray. He had the thermometers soaking in the Wescodyne. It was full strength. I looked at that dark stuff and I asked him what the strength was. He proudly said, "Full strength, ma'am." But he had not read the guidance on the procedure for sterilizing the thermometers. This is the type of thing that the civilian RN working that clinic should have been aware of and was not.

MAJ Gurney: All of this came out of your increased responsibility and input due to the MEDDAC concept?

BG Dunlap: I had responsibility not only for the hospitals but also for any of the clinics in the Area.

MAJ Gurney: Particularly the professional activities at the clinics?

BG Dunlap: The military clinics and the industrial health or occupational health clinics on these posts. If I may, I'd like to dwell on that just a little bit.

This required that I be on-site, first and foremost to find out what was going on. I needed to try to establish the core of a relationship and not rock the boat at first. Then I would go back and evaluate in my own mind what was going on. Later, on the next visit, or maybe not a visit but a telephone conversation, we'd discuss some of these things depending on the staff I was working with. Some of them were so eager and had wanted to do things like this for a long time that they were anxious to start. But they didn't have the support to do it. Then, when emphasis was put on it from the Army Area level, they were able to do these things. By the same token, some of them didn't want to do it. I had to try to come up with the way it would be done.

MAJ Gurney: How did you straddle this marvelous balance between wanting to influence the activity yet maintaining rapport and the openness to bring it about? How do you advise someone to do this?

BG Dunlap: First of all, I had to establish a personal relationship where the person felt that I knew what I was doing. We have to have mutual respect and appreciation for each other's position. The way I approach it is based on that. If I'm aware of the situation they're in, I can only push so far until I tried to help remedy their situation through the Surgeon.

Or, I could go in through the chief of Professional Services at the Army Area. I was fortunate. The chief of Professional Services at First Army was Colonel Mims Aultman. Colonel Aultman was a graduate of a hospital administration program. He was a bachelor and the best cook in the headquarters. He brought cakes in all the time to the staff. He's now at the Soldiers' Home. He's the administrator of the Soldiers' Home.

He was truly committed to making this concept work. He understood and appreciated the role of the Army Nurse having been in hospital administration. The students in the residency programs worked together enough that we all gained an appreciation of each other's professional arena. I think he was in the class with [Major] Mary Frances McLean. I'm not sure. I could come back after visiting one of these places, and discuss it with the chief of Professional Services or the preventive medicine officer. Colonel John Painter was our preventive medicine officer. I could discuss these things that I found without going to the Surgeon. Is this or that right? Why are they doing these things? Are they within regulation doing it? If not, why not? What can we do? We were all in staff positions. We worked together to emphasize guidelines being developed in First Army. If you evaluate against one of these guidelines or Army Regulations, and they're not complying, then you can require compliance or justification for non-compliance. Sometimes there is good justification for noncompliance. What's the alternative then?

This was a new experience for me, too—working with the civilians—the old-time civilians. I truly did not know as much about occupational health as they did. They had been in the field for long periods of time. I had to learn. I learned there's a hygiene agency. I wanted to bring our community health nurses into this. For example, the community health nurse at Fort Knox, Blue Grass Arsenal, came under Fort Knox MEDDAC. The chief nurse or the community health nurse at Knox was responsible for making visits out to these clinics. I didn't do all this by myself.

There was a clinic at the Greater Pittsburgh Airport. This airport had a civilian and a military side. The clinic was New Cumberland Medical Clinic, Greater Pittsburgh Airport. We had a health clinic on the military side. There were missile sites throughout the hills in the Pittsburgh area with little health clinics. In the past, they knew we had no nursing supervision of these clinics. There were no specific standards for nursing procedures or nursing care. They really had been neglected.

Some of them liked to be neglected and not have nurses coming out. But on the whole, they really accepted it. This was quite an experience for me as chief nurse of an Army Area. The chief nurse at the MEDDAC then had to work with all these little clinics within her area. She had to establish these relationships like this.

MAJ Gurney: Related to the emphasis and the concern you had about the occupational health nurses and the industrial health clinics, was that same level of attention needed in all of the Army Areas? Or was this just an area of particular concern to you and therefore your focus?

BG Dunlap: I can't say. I don't know the major concerns of the chief nurses of the other Army Areas. There were not as many of that type of clinic in some of the areas as we had in the First Army Area. The implementation of the MEDDAC concept lagged in the other Army Areas in comparison to First Army. I certainly give Colonel Pixley credit for that. This was a concept that we needed to implement. We had regulations to implement it. And, we went all out to do it.

Although she had no authority per se, Colonel Short in Fourth Army Area established a relationship with the personnel in the clinics. She came back and talked to the preventive medicine officer about things there. But there had been quite a change in the role of the Area chief nurse between 1950–53 and 1968–71 when I served in the role. The Area chief nurse was not as independent as she was when Colonel Short was chief nurse in Fourth Army Area.

But in any area where there were the industrial operations The Surgeon General's Office depended on the Army Area Surgeon's Office to implement the MEDDAC concept. The chief nurses played an extensive role in all aspects of all health care facilities within that Area. We in First Army felt we were in the forefront of implementing the change. Often Colonel Pixley and/or I would have to make presentations about MEDDAC implementation. They had me come down to the Academy [of Health Sciences] to speak on that in 1969 at the Chief Nurses' Conference. I also came down to one of the workshops at the academy in February of '70 to speak. This was a real, real interesting aspect of Army nursing.

What is the structure today? I don't know. The Army Area concept has changed. You don't have a surgeon and a chief nurse in an Army Area. It all comes under Health Services Command now.

MAJ Gurney: But there's been a greater emphasis on regionalization through the medical center. Each medical center now has its region and MEDDACs—the smaller facilities—come under a medical center. If you wanted to you could draw a perhaps slightly incomplete analogy considering the medical center as the Area with its set of MEDDACs. Also, each MEDDAC may have satellite clinics.

BG Dunlap: Let's go back to First Army. Walter Reed's the medical center up there in First Army Area. At Fort Knox, does the chief nurse at Fort Knox then have supervisory responsibility of nursing activities at these industrial clinics?

MAJ Gurney: Yes, she has responsibility. Again it's a delicate balance; she doesn't have line authority in terms of command and control or rating authority, because that clinic commander has a lot of control. It's a constant battle to try, for instance, to put the clinic's nurses within a chain that has a nurse in that rating scheme.

BG Dunlap: I'm thinking particularly of the civilians, for instance at Blue Grass. Does the chief nurse at Knox have responsibility for the nursing service at Blue Grass to the extent that she goes out and sees what's going on? Does she coordinate then with any health officers back at Fort Knox if the clinic comes under them? Or, does she coordinate with the occupational health nurse who now comes under the preventive medicine officer? This gives an occupational health role then to Army nursing.

MAJ Gurney: The community health nurse and occupational health—they're rolled into the same structure. The same person may not necessarily do it, but they have overlapping roles.

BG Dunlap: Are they assigned to the chief nurse? Or to the preventive medicine officer?

MAJ Gurney: It could vary, but usually it's the preventive medicine officer.

BG Dunlap: In my situation, they were assigned to the preventive medicine officer. This is something I really think is important in the history of our Corps. We're considering the roles of the Army Nurses. As they continued to civilianize clinics and other elements of care, the supervision of occupational health nursing was a "whole new ball of wax" as they say, under the MEDDAC concept. I was very actively involved in it. It would be interesting to see what's being done now after this effort.

MAJ Gurney: I don't think we have the volume of "industrial clinics," as you term them. We might now call them Army health clinics. I don't think we have the volume that we had at the time you were an Area chief nurse. We don't have the industrial mobilization that we had at that time because of Vietnam.

BG Dunlap: Watervliet Arsenal was in New York. Natick [Massachusetts] Arsenal also had a clinic. That was an interesting one. It came under Fort Devens. [Lieutenant Colonel] Maggie [Margaret] Bailey was chief nurse at Fort Devens at the time. That was really interesting to go to Natick to the health care facility to see how the nurses were involved.

MAJ Gurney: Were they [the nurses] involved in testing at the research and development facility at Natick at all?

BG Dunlap: Civilians operated the health care clinic. They weren't involved in the tests that were going on. No. Their mission was to provide a health clinic for the staff. They provided area-based care. I felt so strongly about teaching. So I was interested in finding how much the health care staff knew about the employees and particularly about their families. This would probably be called invasion of privacy today. But I feel if you have an employee that has a high absence rate, why? Is it a health problem? Does the person have a diabetic wife? What kind of care is the diabetic wife getting? What does the employee know about diabetes to try to help him see that his wife's disease is controlled? How much do they know about the plant? How many times have they been in the plant?

Where they were and what they did raised a lot of concerns from our viewpoint. These clinics were in outlying areas. They needed to have emergency disaster care because some of these sites had lots of explosives, ammunition, chemicals. How much emergency capability did they need? Did they have an ambulance available? Will it go out there? What kind of equipment do they have on it? How is the equipment checked? What is the training of the personnel to use that equipment? This was a whole new can of worms. (Laughter)

All of this became the responsibility of the First Army surgeon and ultimately the commander of the MEDDAC under the MEDDAC concept. Did the commander then depend on his chief nurse for the nursing in that MEDDAC? That was one area that I felt that I made a contribution to nursing. I feel I helped by establishing a prototype for implementation of the MEDDAC concept.

Okay. Now I can get off that soapbox! (Laughter)

U.S. ARMY RESERVE TRAINING

MAJ Gurney: I was wondering if you wanted to switch over and think about the activities with the reserves at this time.

BG Dunlap: Okay. At that time the First Army Area had the largest number of reserve hospital units in the system. These were concentrated in a small area. This

was during Vietnam. If you looked at our reserve units at that time, we had many dedicated people in them. But also we had some who were not as dedicated. The training—the readiness—of the reserve units varied, as it would with any unit, with the leadership in the unit and the support of that leadership by the reserve command. I may get confused about this. This is when they reorganized to place more emphasis on readiness. They established Readiness Commands so that they had a Readiness Command almost like an Army Area Regional Command. That established another command level to work through. Plus, the readiness areas didn't correspond to the Army Areas and the MEDDACs. Sometimes we might have to coordinate with two organizations.

Colonel Pixley felt very strongly about training because he had been the commander at MTC [the Medical Training Center at Fort Sam Houston]. He had been responsible for the training. The Medical Training Center at Fort Sam Houston was where all of the enlisted personnel trained.

MAJ Gurney: Is this the same, or is it different from MFSS?

BG Dunlap: It's different. It didn't come under MFSS, it was separate. He commanded it from there. At MTC they had all enlisted training. It was the same training that is under the academy now. All of the enlisted came for their basic medical training here. Then, they came for their advanced training in our other courses.

Colonel Pixley felt so very strongly about training our medics and particularly our enlisted medics. Working with the reserves then, he felt very strongly about the training in our reserve units. At that time reserve units were scheduled to come for their summer training. That's what it was known as—summer training. The whole unit came on duty for training at one of our medical facilities. For instance, the first two weeks of April the whole unit might go for training at Fort Devens. At that time though, the coordination between the staff at Fort Devens and the reserve unit was kind of nil. I seem to always be going back to the theme that it depended on the leadership. But that is the root of it all. The involvement of the leadership down to the nursing level, the coordination between the chief nurse at Fort Devens and the chief nurse of the reserve unit coming on duty, was very sketchy but oh, so important.

The chief nurse at Devens needed to be informed that this certain hospital unit would be reporting in on Saturday or Sunday. She needed to know that they'd be coming in on Monday for two weeks. She needed to know how many were coming. She needed to know what MOS's would be represented. She needed to know how well qualified they were in their MOS. She didn't truly know the training needs of the unit. It could be a unit that had 91 Deltas in the operating room that worked in civilian hospitals as surgical technicians. They may have had a great deal of training. Or, it could be a unit where the 91 Deltas had gone through the basic courses and that was it. We had one unit that had a professional football player serving as a 91 Delta. He certainly was not getting any 91 Delta training in his non-reserve time. Back in the unit during the year, he wasn't getting 91 Delta

training. They were concentrating primarily on military subjects, not on 91 Delta training. We found this throughout the units.

It really became a mission for Colonel Pixley and myself to see to it that the reserve units were receiving the medical training that they needed to keep them qualified for their MOS. We also felt that it was not fair to the reserves for the hospital where they were training to say, "Oh, Goodie. We're having some more staff coming in. So, we'll schedule all our leaves at that time." It worked both ways. So they didn't leave them there as the primary staff on those units while they were there. We felt that parallel training should be implemented.

We felt that a great deal of pre-summer camp planning and conferences should be held and the nurse should be included in those pre-training conferences. If a hospital unit was planning to go to Fort Devens there should be development as they moved along toward their training dates. If the whole unit was going in, then the nurse should be involved at that training conference. Coordination between the chief nurse at Devens and the chief nurse of the hospital unit should go on so that the things that I was talking about were clear. The chief nurse at Devens would know about the soldiers coming in for training. They should know if they have so many 91 Charlies who need training in doing some task. Or if they have people assigned to work in intensive care units who don't work in intensive care units in their civilian employment, they need that training. They needed to work together with the chief nurse at Fort Devens to plan to meet the training needs of the reserve unit and yet still utilize the skills of some of those reserve people to help the people at Devens.

Also, who is going to supervise the reserve nurses? What are you going to do with the chief nurse and the assistant chief nurse assigned to the reserve unit when they come on duty at one of those hospitals? Are they going to stay over with the reserve hospital staff? Or are they going to be working with the chief nurse of the hospital? These things had to be worked out. I feel that the chief nurse of the reserve unit should function as chief nurse of that reserve unit. But the chief nurse of that reserve unit and the chief nurse of the hospital have to work together. But she should have the experience of supervising her staff. Her supervisors should have the experience of supervising their personnel working with the parallel supervisor of the hospital in those areas.

This concept took an awful lot of work. We developed another concept later on. Why on earth bring all the people on duty at one time for two weeks in the summer? They would inundate the hospital with more staff than they needed and they couldn't provide them the training they need. Why not bring them on throughout the year? We were getting pretty short staffed in our hospitals. Vietnam was still ongoing. Why not bring them on throughout the year so that they could meet training needs in the reserves and provide staffing support in the hospitals. So this was developed. I had a reserve person on my staff. Garnett Willa worked over at OCAR [Office of the Chief, Army Reserve], and she worked with us on some of this. I saw it implemented. We implemented it in First Army.

The reserve did a lot of their training on weekends. Spurgeon Neel was the Deputy Surgeon General. He often went to meet with the reserves on the week-

ends in these different units. I went out in First Army as the chief nurse to talk about nursing in the MEDDACs and in the reserves and what was going on. I talked about the programs we had with the reserve units.

Colonel Pixley also went out to these units. The reserve units really got to know us. When the reserve headquarters staff came in for their reserve training to First Army headquarters, we really set up programs for them. They'd also conduct conferences for the reserves in First Army. We set up some tremendous conferences for them. They loved it. They were anxious to talk and meet, to be back with the military again, and to get the attention that they needed.

MAJ Gurney: Were these programs for spreading the reserve training throughout the year, and for assuring appropriate training universal throughout the Army Areas?

BG Dunlap: They were implemented to my knowledge. This is an initiative that they tried to implement throughout the reserve.

MAJ Gurney: As you look back, what do you feel was the legacy that you left at First Army?

BG Dunlap: The MEDDACs, the reserves, and the third area was with the IG.

INSPECTOR GENERAL TEAMS

MAJ Gurney: What was that? Tell us about that.

BG Dunlap: Each Army Area headquarters was responsible for conducting its IG [Inspector General] inspections. We were supposed to say IG "teams," I think. (Laughter)

Each Army Area would participate for the medical facilities in their area. This meant that they had the IG team from First Army go out to visit. They had a regular schedule throughout the unit that they visited. When they went to make their visit they contacted the First Army surgeon and asked for a representative to accompany the IG team just as they did in civilian personnel or any other field, to make the IG inspection on that particular post. The precedent at First Army was to have either the chief of Professional Services, who is a physician, or the chief of Preventive Medicine, a physician, go out to inspect the medical activities. Colonel Pixley called me in one day and said that the IG team was going to Fort Knox. He had nominated me to be on the IG team from First Army to go to Fort Knox based on my hospital administration experience.

This was quite a good experience for me. The rest of the team was male. They were used to going into a post, and they'd put them up in visiting officer quarters, or something like that. The men would each go out and they would inspect their areas. Then, in the evening they'd come back. They had one sergeant on the team who was the best cook. They would cook their meals and sit around in the lounge in that BOQ [Bachelor Officers Quarters]. Either we'd cook our own meals or

he'd cook our meals, or something. We'd sit there and review the day's function. They'd discuss their findings in this area or that area. Perhaps someone found a civilian personnel problem. They'd discuss it with the one on the team doing civilian personnel. A lot of that was done during the evening hours. Prior to the time that I was on the team, it was done really informally as far as dress and whatnot. But then, when I came on the team, gosh, those men were wonderful. They wouldn't let me do any of the cooking. I was a good cook. But no, I was treated like a queen on the team. They still were casual in their dress, but not as casual as it had been prior to the time that I was on the team.

The way we functioned, we always had our team briefings. We went to the post. We conducted the entrance interview, a briefing by the post commander and by our IG team leader. Then we each went to our own particular areas and conducted the entrance interview with the commander of the MEDDAC. I'll speak now for mine. After we finished the entrance interview with the commander of the MEDDAC we presented him with a schedule of how we wanted to conduct the IG visit. It also laid out what we expected to have available to us. Then, we were on our own to do it. Each evening I met with the rest of the team and discussed the areas and coordinated some of the findings. We tried to help each other that way.

We had an after action review with the MEDDAC commander. Prior to the after action review with the MEDDAC commander, we were already working with the IG team to come up with our findings and what our recommendations were going to be to the MEDDAC commander. These recommendations were turned in to the IG team leader and they became part of his after action review with the post commander. They became the report of the IG team back to the Army Area. Then, a report was issued from the Army Area to the post that was inspected. The post then had to respond to the findings and describe the actions taken.

Fort Knox was the first time I participated in an IG. It was a very interesting one. I did not know who the MEDDAC commander was. Wait a minute, I take that back. I knew the MEDDAC commander. He had been my commander in Okinawa, Clark B. Williams. I respected him. We had enjoyed such a good relationship in Okinawa. But the executive officer was an MSC officer who had been a classmate of mine in hospital administration. He had set up a schedule for what he thought we would want to visit. He told the chief nurse and the commander, "Don't worry, She'll spend most of the time in nursing service." Well, it just so happened that I had a very good relationship with that chief nurse at Fort Knox. I knew what was going on in nursing service at Fort Knox before I ever got out there. So, when I had my entrance interview with the commander and the executive officer and presented the areas that I wanted to visit and the time I wanted to spend there on my schedule, I had very little time in nursing service. That threw this executive officer into a spin because I was going to spend as much time in other areas as I was.

The way I went about doing this was that I reviewed all of the ARs [Army Regulations] that pertained to the hospital organization. When I arrived at the

MEDDAC, I told the commander—prior to my visiting the individual areas—that I wanted all the hospital policies. So I reviewed the hospital policies that pertained to that particular work section, for instance, the Registrar. When I visited that area, I really tried to identify, first, if they were complying with hospital policy. That was my concern. First of all, I review the hospital policy to see if it was complying with the AR. Then, I checked to see if they were operating in compliance with hospital policy. If not, why not? What was the variation? This was really interesting.

One of the issues that arose was to identify people who should have emergency tags. They were sensitive to certain things. This was to be on the patients' charts. It was interesting how many of them were not on the patients' charts. There were things like that of concern to me. So, that was my approach. It was quite a surprise to that exec officer that I went into as much detail as I did in areas that had been identified as major areas of concern and minor areas of concern. He thought I'd spend all my time in nursing service. I enjoyed the work.

I also visited the industrial clinics. I made an IG team visit to Carlisle [Barracks, Pennsylvania]. Colonel Marion Johnson was there.

MAJ Gurney: Marion Johnson—oh, yes. I remember him.

BG Dunlap: He was the exec officer at Carlisle Barracks. He had been a student of mine in hospital administration. You should have asked him last night about my IG inspection. (Laughter)

Lieutenant Colonel Wilma Chalmers was chief nurse there at the time I visited Carlisle Barracks. I used the same approach. Know the ARs, hospital policy, compliance with hospital policy. If not, why not? I didn't do it just during 8 to 5. I came back and I observed the hospital operation around the clock during this visit. It was a learning experience for me. Plus, it enabled me then to make observations that could be of help to the IG team in their reports. It helped provide information to the hospital commander, the chief nurse, and to our First Army Surgeon.

We've talked about the conflicts that we find ourselves in as staff officers sometimes. That conflict is between our loyalties to the Army Nurse Corps and to the staff agency. There was no question in my loyalty to both. I felt a great loyalty as chief nurse of the First Army and a responsibility to the chief nurse of that hospital. There were things within nursing service that I found that I felt were strictly nursing. By discussing them with the chief nurse, they could be solved at that level. However, I let the chief nurses know just as I did the other elements there. I asked, "Are there any areas that you're having difficulties with that involve the commander or the post that pertain to nursing? If there are, what can I do to support you?" I mentioned to you that in personnel there had been problems with the underlap of civilian personnel. The chief nurse was not getting support from her own personnel in the hospital. The post Civilian Personnel [Office] was not helping fill this underlap. By me bringing this situation to the attention of the IG team members and civilian personnel, they could look into why it was not being done

at the post level. At that particular post it had to be a part of one of our minor findings on the IG team report. By bringing it to that level it was resolved.

I felt that I was supporting the post and the hospital commander. But I was truly supporting the chief nurse of that hospital. As the medical representative to the IG team, I looked at all areas, not just in nursing but also logistics and many of the others. I was able to provide a great deal of information to my surgeon at First Army and the other staff members at First Army. I supported the hospital with information that might not even go to the IG team so that they could solve the problems at their level. But those problems that couldn't be resolved were brought to the IG team and, through their report, to the First Army commander. The First Army commander had command authority over post commands. That's important.

MAJ Gurney: Was the activity on the IG team really effective in increasing your effectiveness as a chief nurse in the Army Area?

BG Dunlap: In the Army Areas, yes. I felt it very strongly. Indirectly, it was also true that it was helpful to me during the time I was Chief of the Army Nurse Corps. When you're Chief of the Army Nurse Corps, every problem about nursing is yours indirectly. You're responsible for nursing service for the Army.

Those are the three biggest issues as I look back. Those were areas of real intense involvement during my time with the First Army. That brings us to the time that I was contacted about a change in assignment. That was in 1971. I entered the Army Nurse Corps in 1942. At that time I had about twenty-eight years' service, didn't I?

[Lieutenant Colonel Dunlap was promoted to the rank of Colonel December 31, 1969.]

CELEBRATING THE FIRST ARMY NURSE CORPS GENERAL OFFICER

MAJ Gurney: I was going to ask you what your response was, around June of 1970, when you found out the Chief of the Army Nurse Corps would be a brigadier general.

BG Dunlap: I'll tell you what my response was. "I can't believe it. Isn't it wonderful!" Here's where I was when it happened. I was in Miami Beach attending an ANA convention. I think it was ANA, not NLN. It was their national convention. We drove down there. Lieutenant Colonel [Irene R.] Pishak and I were driving, on the way back to Washington. We were going to stay a few days at Virginia Beach. We were driving along and we heard something on the radio. Oh, no, before that, Anna Mae [Hays] was down at the convention. She had just gotten down there and was called back to Washington. It was so secret. We didn't know why she was called back to Washington. What's the matter? Is there some big flap going on? Or what's happened over in Vietnam? Or what's going on that she didn't get to participate in

the conference? Well, we didn't know what on earth had happened. So, on the way back, we hear this thing on the radio. It was something about women generals. We could hardly wait for the next newscast to see what it was. It was the announcement that Anna Mae [Hays] and Elizabeth Hoisington had been selected for promotion to general officer. I didn't drive off the highway. But I almost did.

MAJ Gurney: Oh, my.

BG Dunlap: We were so excited! This was just tremendous to have a promotion to general officer.

That's why she had to go back so quick from the convention. It was on the news and in the newspaper too. When I got back to First Army we found out when the ceremony was going to take place. I started coordinating with [Colonel] Louise Rosasco, who was the assistant chief of the Corps at the time. We started planning for a celebration of her promotion.

I served as chairman of the committee and met with the chief nurse at Walter Reed. I can't remember who in The Surgeon General's Office was on the committee. We planned a celebration at Walter Reed's officers' club for the evening following her promotion. I tell you, we planned a celebration! I have pictures of it to show you if you haven't seen them. We had the big star and got a great big champagne glass. Inez Haynes [Colonel, Retired] came for it. I remember that. I got a little tiny cannon, and we set it up so that the cannon could be shot. We had the first cannon salute for her! (Laughter) It was her first as a general officer!

The nurses of the MDW [Military District of Washington] area, First Army, Walter Reed, The Surgeon General's Office, Fort Belvoir all celebrated. I think some came from Carlisle Barracks too. Nurses from all over our area came in to have a promotion celebration for her. We were all just popping with so much pride and joy that the Chief of our Corps was a general officer. It was infectious, really. The entire Army Medical Department was celebrating. The response was wonderful. It was long overdue for the Army Nurse Corps. Really, everyone was so pleased for the Army Nurse Corps that it happened.

I went back to work as chief nurse at First Army. That was in June of 1970. Anna Mae's—General Hays'—tour was to end in September of 1971. Naturally, there was much talk of who was going to be the next Chief of the Army Nurse Corps. Just as there is today—who's going to be the Chief of the Army Nurse Corps? There's always speculation. You know who the senior people are in the Corps. You know the ones who don't have enough time left to be the Chief if they have a mandatory retirement.

I was approached that I was due for a change in assignment. I had been at First Army for three years. It was time to move to another assignment. In November of 1970, I had twenty-eight years' service completed. I thought, well, I just have two more years until I have my thirty-years' service. Where do I want to go those last two years? I really felt that throughout my career, I hadn't raised much stink about my assignments. But, at that point I thought I didn't want another overseas tour. Coming back from overseas and retiring isn't that easy.

At that time there really weren't many chief nurse assignments for full colonels available. I wanted to be chief nurse at Walter Reed. But I wasn't so sure I was going to get that assignment. Gladys Johnson, who'd been the assistant chief of the Army Nurse Corps, had gone out to Walter Reed as chief nurse. She decided that she wanted to retire, making that position available. I was selected then to move in to be chief nurse at Walter Reed. My plans at that point were to spend the last two years of my career as chief nurse at Walter Reed. I felt, what greater way to end a career as an Army Nurse than to be chief nurse at Walter Reed? I would then retire after two years.

Walter Reed Army Medical Center

MAJ Gurney: When you went into Walter Reed, where did you see you wanted to have some impact?

TRANSITION TO WALTER REED

BG Dunlap: I had twenty-eight years' service. I thought, I have two years in this leadership role. This will be my last tour. And it would be two years. I had never been stationed at Walter Reed and had never requested it when making out a preference statement. I had always said, "Assign me any place west of the Mississippi." I had no desire to go to Walter Reed. I didn't want to be up in that busy Yankee country. However, having already spent some years up there in the Washington area, I realized that Walter Reed really was one of our top medical centers. I thought that this would be tremendous to spend the last two years of my career in the clinical setting again. My original goal had been to be chief nurse of the hospital and therefore in the clinical area as opposed to being at an Army Area headquarters or staff office or something like that. That's what I was looking forward to—being back in a hospital environment.

I had not been directly responsible for hospital nursing services since I'd been chief nurse in Okinawa, which was in '65 and '66. Although at First Army I had had overall responsibility, I knew what was going on in hospitals, but it was not down to the level of day-to-day operation of the hospital. I don't want to say it was frightening, because it wasn't. I was too stupid to be scared. But I thought to myself that this was truly going to be a challenge. I don't want that to sound like a trite expression. But, because I had been out of the clinical nursing setting for a period of time, I knew that going into the big hospital with its large staff would be quite a challenge to me. I had gone through a similar transition at a different level. Remember, when I went from Incarnate Word in 1954 to Neubruecke, Germany, and became a head nurse of a dependent ward I had been out of the clinical setting for a long period of time. I realized how much catch-up I had to do to even become familiar with medications. Well, that was back in the '50s. So much had happened between that time and '71 when I was going into Walter Reed that I thought, oh, there is so much I don't know about clinical nursing. As chief nurse, I'm really going to have to learn. For example, we had intensive care

units, coronary care units, and things like this. I felt I've really got to learn so much. But I really wanted to go to be chief nurse. So I went there with the idea that this would be my last assignment. I would do the most I could and enjoy it as much as I could, before retiring.

When I got there, I was very fortunate that I had [Lieutenant Colonel] Mary McHugh as my assistant chief nurse. She could have been chief nurse of that hospital instead of me. She was such a tremendous person, and such a support. We had a secretary, Ada Bennack, who had been secretary to the chief nurse quite awhile. She was a very capable, competent, lovable, likable person. Everybody just loved her there in nursing service. I had some really fine supervisors and staff. I knew them because some of them had been students of mine. For some of them I had been involved in making their assignments to Walter Reed. So I knew them. I felt that I really had support. All I had to do was a lot of learning during that period of time. With only two years, you can't rush into anything, you can't turn everything around from the start. I went to learn. The commander was [Brigadier] General [William H.] Meroney who had been the deputy chief of Personnel in The Surgeon General's Office when I was chief of Army Nurse Corps Assignment Branch. I was looking forward to working with him again. It wasn't a threatening situation—as threatening as it might have been if I had moved into Walter Reed without knowing that much about it.

My first plans were to organize my manner of operating. We had a morning report as they have in many hospitals. One question was, who was I going to have participate in the morning report? In addition to the night personnel, who do you want at that morning report? I know that [Lieutenant Colonel] Edith Nuttall was on assignment at Walter Reed as my nurse methods analyst. But she was also working in The Surgeon General's Office planning for the new Walter Reed. So I wanted her at the report. Fortunately, she lived on that side of town and could be there. We set up a system for morning report. Next, what kinds of meetings did I need then to communicate with staff? Do I want to have head nurses' meetings? Do I have supervisors' meetings? Or do I have nursing service meetings? These were things I had to think through concerning how I wanted to communicate with such a large staff.

I spent the first part of my time getting an orientation from each of the section supervisors about each of their sections and meeting the people on their sections. That took quite a while. I had to meet the doctors, the staff, and get to know them. That took a while to do that. During that time we began to get actively involved in planning for the new Walter Reed. They were preparing to start knocking down what they referred to as the back wards. Only the façade, the administrative building, and wards with it were going to be kept. They planned to knock down all those old back wards. Our problem was, where were we going to relocate the different services? I insisted that I be on the committee working on this. But I established within nursing service a nursing committee with the supervisors of the different sections and their NCOs. With that group we could come up with recommendations for combining and relocating that I could take to the larger committee.

I think particularly of [Lieutenant Colonel] Lorene Keneson, who was a supervisor and later became the chief nurse out at Walter Reed. She had the sec-

tion of the main hospital to the left of headquarters. We had to relocate ENT into the area to combine it with the GU section. We never think of ENT and GU together as a unit. Everything was already crowded. How were we going to combine the sections? It did require some minor construction to manage it. Not only did we have to plan the physical moves, but we had to plan staffing because that unit would have two complete sets of doctors.

One problem that I constantly battled was that the space in the relocation was to be used for patient care, not for doctors', residents', and interns' offices. There would also have to be plenty of space for the secretary. They had a tendency to want to be sure that you first provided for those offices. Then, with what was left, you added all the beds. Some people really did expect that. So that was a consideration. People who knew Walter Reed at that time know how crowded it was. It was quite a challenge to be able to combine services and still make it tolerable for the patient and the staff to provide care. So, we worked on that. It took a great deal of time.

INFECTION CONTROL NURSE

I was concerned about the utilization of the infection control nurse. This was a fairly new concept. Janie Sinclair had been the infection control nurse at Brooke in San Antonio. She was one of the first ones there. She later became chief nurse at Brooke. Walter Reed, though, was an entirely different organization. How could we have an infection control program at Walter Reed? I insisted that the infection control nurse, although assigned in preventive medicine, attend the monthly chief nurse's meetings. These were regular meetings with the supervisors and chief nurse. That way they would know what was going on throughout the hospital that might relate to infection control. We really spent a good deal of time in that area.

One of my pet peeves was those cotton-pickin' wool sweaters. We tried to insist that nursing personnel put on a clean uniform every day when they came to work. Most of them lived off post. All of the officers certainly lived off post there at Walter Reed. They traveled long distances to come in and they would stop and do shopping on the way to and from work. I just didn't want nursing service personnel to do that. Then, they came on duty in the patient care area in their white uniforms. We talked a good deal about that. I said, if we insist on a clean white uniform and then they wear those green sweaters that don't get washed or cleaned every day, what have we accomplished?. What are the chances of carrying infections back and forth? So I asked the infection control nurse to really look into that, the problem of the green sweaters. It was not conclusive during my short tour at Walter Reed. But we worked closely with infection control and the role development of the infection control nurse.

I'm trying to think of some other things.

MEDICAL DEPARTMENT COUPLES

MAJ Gurney: During this stage in the Corps' history, as we matured, there were a lot more Nurse Corps officers who were marrying other soldiers or other offi-

cers, perhaps doctors or other nurses or medics. Did you encounter that at Walter Reed? What were your thoughts on that?

BG Dunlap: Yes. We began to see more husband and wife teams in the medics. We had a situation where we had a husband and wife team in nursing. The wife outranked the husband a great deal. Also, the wife was in a supervisory capacity. The decision had to be made about where to assign the husband consistent with his specialty and according to his rank and experience. I felt very strongly that we should not place either one of them in a difficult position that could become an embarrassing situation for them. Also, that the ranking officer should in no way be in a supervisory capacity over the junior member of the couple. I realize that sometimes, in making those decisions, you may jeopardize or not fully develop the potential of one officer's career. But I had to think about all of nursing service. If you had one supervising the other then you'd have to deal with efficiencies, preference of time assignments, and days off. No matter how hard I felt the supervising officer tried to make an effort to be objective, it could be and would be interpreted by some as not being fair. She could be accused of playing favorites. I just did not want to put the two of them in that situation. So, that was the way I handled that. I worked out an assignment that placed them in different chains of command. It worked. They agreed to that arrangement.

MAJ Gurney: What about marriages between officers and enlisted members? Or between doctors and nurses? Did you encounter any of that?

BG Dunlap: Doctors and nurses? Not at Walter Reed. No. We did have nurses and enlisted personnel. The customs of the military at that time were that they're not supposed to socialize. The situation was handled beautifully by some of the couples. When there were command functions at the officers' club, if the nurse was married to an enlisted person, her husband wouldn't come. It would avoid a potentially difficult situation. Sometimes the nurse did not participate in the event. But remember, we used to be able to have "command performances." I don't know how many of those they have today.

How it was handled depended on the couples. I didn't encounter any difficulty during that short period of time. I can't think of a specific case where there was any difficulty. But I was aware that there were difficulties in other situations. Usually it was just poor judgment on the part of the couple regarding how they conducted their social life. At Walter Reed everybody lived off post. In their civilian community, they could go shopping as husband and wife. They could belong to the church and be involved in all kinds of community activities that would not even be known within the military community. Difficulties did arise on the smaller posts where there was family housing. On those posts everybody knew what everybody else was doing. But I didn't have that at Walter Reed. I did have the situation of a husband and wife nurse team.

INTERFACE WITH WRAIR

The other topic I wanted to cover was nursing research.

At Walter Reed we had the Walter Reed Army Institute of Research [WRAIR]. We had nurses assigned to WRAIR. WRAIR had a research unit or ward in the hospital [Kyle Metabolic Research Unit]. The staffing of that unit came under WRAIR. But I was director of Nursing Activities of Walter Reed Army Medical Center in addition to being the chief nurse of Walter Reed General Hospital. I held a dual hat. Therefore, I did have responsibility related to that nursing unit. This was a relationship that needed to be defined. What was the responsibility of the chief nurse of the center for nursing being given there? The nurses at WRAIR weren't given that responsibility. It was the doctor who was in charge of that unit who felt he was in charge of everything up there in that unit. Those nurses were his nurses. No one else was supposed to have anything to do with them. Maybe it's a good thing I only had a short tour there.

MAJ Gurney: Didn't the Kyle Metabolic Unit come under Research and Development Command? And, because of that, was it not entirely out of the hands of the Medical Center?

BG Dunlap: The Medical Center per se perhaps, but you can't have a unit entirely independent. For instance, consider the burn unit at Brooke [Institute of Surgical Research]. It isn't assigned to nursing service. The nurses are assigned there directly from Washington. They have their own chief nurse. But the chief nurse at Brooke has certain responsibilities to the commander of BAMC as far as nursing activities of the unit. She may not directly supervise it. But if they get short of nurses or enlisted personnel in that burn unit, you know who they'd call to help to supplement their staff. This, or some similar situation, could arise.

MAJ Gurney: So, you had responsibility in a way, but without authority?

BG Dunlap: Only indirectly. Yes. Roles would have to be defined for responsibility for care and for research too in that setting. The organizational relationships would have to be clarified.

MAJ Gurney: What did you do, in that brief period of time, to try to resolve that? Did you at least set up a communication network that would allow you to have some influence?

BG Dunlap: I worked with the nurses up at WRAIR and with the doctors to get to know the unit and how it functioned.

I was at Walter Reed such a short time really. A good deal of my time was spent orienting to hospital services and then in organizing the nursing supervisory staff the way that I was planning to function for two years. I must share with you a humorous experience there. I received a phone call one day. This came from

[Lieutenant] General Ralph Haines who lives in San Antonio now. He was the commander at CONARC. He'd received a phone call from a former patient at Walter Reed who was complaining because the nurses' uniforms were too short. Remember, this is the period of miniskirts. Trying to get the nurses and enlisted personnel to wear the white uniforms at what we considered a professional length was pretty difficult. They wanted to be stylish. Those skirts got shorter and shorter. This former patient called General Haines complaining about the length of uniform skirts at Walter Reed. He had been a patient on the coronary care unit. Just when his pulse and his heart would be slowed down where he was doing all right, they'd send one of these nurses in there. When she'd bend over . . . (Laughter)

I'm telling you this was serious. (Laughter) Her skirt was so short. That would really get his pulse and his heart out of sync, you know. He thought he never would get out of that coronary care unit. Couldn't something be done about the nurses wearing such short uniforms at Walter Reed? Well, you can imagine my reaction to it. I thought he was kidding me. But he wasn't. (Laughter)

There wasn't anything more I could do about that than what I was already doing. I was trying to ask the supervisors not to inspect their staff but to pay close attention to the uniforms and to be sure that they were clean and neat and professional looking. If the uniforms were too short, bring it to the attention of the person. I did talk with the detachment commander about it to see if perhaps she would say something about it to the soldiers. But, of all the problems that a chief nurse has running a big medical center nursing service, that really took the cake. It was humorous to me that monitoring skirt length should be an expectation of the nursing service.

ADMINISTRATIVE ASSISTANT IN THE DEPARTMENT OF NURSING

At Walter Reed, this was the first time that I had an MSC [Medical Service Corps] officer assigned as an administrative assistant. This is a concept that we had tried to implement in the '50s. It was a result of the Assistant Secretary of Defense Anna Rosenberg's letter about the utilization of nursing personnel. We were trying to get food service and logistical service to take over responsibilities such as counting linen and serving trays. An element of this was also to look into assigning an MSC officer to serve as administrative assistant to the chief nurse. Just like all of the other chiefs of the departments. I really think that the nurses were their own worst enemies when we tried to implement this. Some of them didn't want to turn loose of some of those things that an administrative assistant could do. Then, someone had the brilliant idea that perhaps this was something that a WAC [Women's Army Corps] officer could do. At that time we still had the WACs. Women weren't integrated into the other Corps; they were separate as Women's Army Corps officers or enlisted. If you looked at the total career opportunities for a WAC officer, they were usually not in an administrative position in the Department of Nursing. Some of the chief nurses didn't really accept this either. So, that concept kind of faded away. Later, it resurfaced. Walter Reed implemented it. We had a really fine young MSC lieutenant as the administrative

assistant to the chief nurse. He really was able to do many of the things that the secretary had done, or that the assistant chief nurse had done. The assistant chief nurse was in turn able to share more of the chief nurse's load.

I found it to be very satisfactory. I know at one time they did not want to have an MSC officer. They said they had an NCOIC of Nursing. Let the NCOIC of Nursing serve in that capacity. Well, the NCOIC should be concerned about staffing and patient care and so forth. Not setting up tours for VIPs or coordinating many of these other functions. There's another aspect, too. At hospital meetings, the administrative assistant represents the different departments. If the administrative assistant to the chief nurse is a sergeant and all the others have officers, there is a difference. This could affect how the recommendations of nursing service were viewed, no matter how good the sergeants were. Many of them were good or better than some of the officers. But we know that. Nursing service was being represented in those forums by an enlisted person. The others were represented by officers—some lieutenants and some captains.

That was my first experience working with an MSC administrative officer. I really felt like I'd taken little babies and was raising them. They were very young MSC officers. I had two different officers during that short period of time. They both were tremendous young men. And they were really interested in what they could do for nursing.

WRAIR [Walter Reed Army Institute of Research] and WRAIN [Walter Reed Army Institute of Nursing] were at WRAMC. I worked closely with the director of WRAIN and was involved in some of the ceremonies and the activities of WRAIN, which were real exciting. We had such tremendous young men and women going into the WRAIN program. Their activities were really interesting and exciting.

COLONEL FLORENCE BLANCHFIELD

MAJ Gurney: During this period of time Colonel Florence Blanchfield died. It was during the summer of '71. She wanted to be buried in Arlington with full honors. There was some difficulty in getting that level of ceremony for her. Could you discuss that?

BG Dunlap: This was after I was notified that I would be the Chief of the Army Nurse Corps. But no one else was to know. I couldn't even tell Colonel Blanchfield. It was hard not to tell her.

I was chief nurse at Walter Reed at that time. That's the first time I'd actually met Colonel Blanchfield. She was a patient. And, bless her, she was such a dear, sweet little thing. The nurses just loved her. The doctors loved her. Everybody loved her. It was a task to keep everybody from trying to go in there to spend too much time with her too. I went to Dallas for an NLN convention. Prior to leaving I went up to see Colonel Blanchfield. I stopped by every day to see her. That's one thing I tried to make a point of. I made sure I was in the patient care area every day. I couldn't go to every area of Walter Reed every day. So, I kind of planned it

according to specific areas and where the sickest patients were. But I did try to get to all of the areas during the week anyway.

I'd get up to see Colonel Blanchfield every day. I stopped by that afternoon to tell her that I was leaving for Dallas. She was sitting there in her chair. She had received her mail, and had a number of cards. I asked her if I could open her cards for her. She said, yes, she'd appreciate it. So, I opened the cards. I was going to read them to her, but I had not taken my glasses with me. I wore Ben Franklins at that time and only needed them for reading. I didn't have them with me so I couldn't read those cards. She says, "Give them to me. I'll read them." (Laughter)

MAJ Gurney: She read them to you?

BG Dunlap: Yes. She'd read them to me. And she did!

I went on to Dallas. The day I returned, Colonel Blanchfield died. I had assumed that The Surgeon General's Office would make arrangements for her burial, since she was a former Chief of the Army Nurse Corps. But I found this was not true. This was a touchy situation. Some of Colonel Blanchfield's friends, Kay Jolliff and Mabel Stout, called me. I told them I'd stop by to see them and Colonel Blanchfield's sister on my way home from work, which I did. I took over the responsibility for planning Colonel Blanchfield's funeral.

There was no difficulty arranging her burial at Arlington and in the Nurses' Section at Arlington. There was also no difficulty, to my knowledge, about the full military honors for her. But in planning her funeral, I was trying to plan something that would be fitting for the Chief of the Army Nurse Corps. So I brought the nursing staff together. What we planned was that the visitation period was going to be in a funeral home right there close to the post [Walter Reed] in Silver Spring. During the time of visitation, I had an Army Nurse Corps officer in uniform over there all the time. I had no trouble getting volunteers for that.

The actual services were held in the chapel at Fort Myer. I invited the former Chiefs of the Corps to be "honorary" pallbearers. Then, we had two representatives of each rank of the Army Nurse Corps to be the pallbearers. We had all ranks except general because we only had one general. She would not be one of the pallbearers but would be down with the chiefs. Working with Fort Myer, the decision was that actually, this group would be more like the Honor Guard. The Old Guard burial detail had responsibility for actually carrying the casket. We had two representatives from each rank, black and white, male and female. All were represented. We were in our Army Blues. Marge Wilson and I were the two full colonels. It had real meaning to it. I planned this because I knew that I was some day going to be an ex-Chief of the Corps.

At the time I thought, if they only knew. (Laughter) But they couldn't.

MAJ Gurney: Nobody else knew?

BG Dunlap: No. It hadn't been announced yet. But I knew. Of course, the former Chiefs were there. We [the Honor Guard] came in and stood there. Then the cas-

ket was brought in. Later, we stood outside as the casket was brought out. At the gravesite, we served as the Honor Guard as the casket came through. Then we stood at the head.

I felt honored to be able to do it. The people who knew her, and those who had served with her, our senior people at that time, retirees and all, it meant a lot to them, too. It was interesting at Walter Reed the day of her funeral. We got a bus to take staff down to Arlington who wanted to go. We needed two buses. I shall never forget one little black nurse, a first lieutenant who worked up on the ward. She just loved Colonel Blanchfield. She wanted to know if she could go. I said, "Sure, you can go." She came dashing down. She was the last one to get on the bus. She had dashed home to get out of that white uniform to get into her green uniform to be there because it meant so much to her. She had taken care of Colonel Blanchfield. She wanted to be there. (Laughter) And she was.

There was a tremendous turnout. People came in from all over the country. Many of the retired nurses were there. That chapel was filled. So, I got involved in that.

Edith Aynes worked with Colonel Blanchfield and was a very good friend of Colonel Blanchfield's. She wrote the book, *From Nightingale to Eagle*. I let someone borrow my autographed copy and it was never returned to me. If you hear of an extra copy someplace, I'd like it. When she wrote the book, there's a picture in there of the nurses standing there. She comments, identifying Brigadier General Dunlap, or something like that. I don't know how she had it in there. But she had something indicating that I'd be the next Chief of the Army Nurse Corps. I don't remember how it was stated.

MAJ Gurney: We talked about Colonel Blanchfield's death and how much everybody in the hospital loved her and wanted to be part of the AMEDD's farewell to her.

Why is it that Colonel Blanchfield was so endearing to the staff? What about her was such that everyone just loved her and was so attached?

BG Dunlap: You've met Colonel Short?

MAJ Gurney: Yes.

BG Dunlap: Okay, in my opinion, Colonel Blanchfield and Colonel Short had many of the same human characteristics. Colonel Blanchfield was a person who we all respected because she was a former Chief of the Corps. We knew of how she fought for the Corps and all that had happened during her administration as Chief.

In Colonel Short, you see many of the same characteristics that we saw in Colonel Blanchfield. They were both a human being who had had the authority, the rank, the high positions, but they never played on those. They were interested in our people as individuals. They told them stories. Colonel Blanchfield shared her experiences just like Colonel Short told some of her experiences. In sharing

those experiences, it wasn't, "I did this and that." The focus was on the experience, not on her.

Our staff recognized that she was sick, very sick, and not complaining. She was just one of those patients that you loved. You really just loved them and hoped you'd be able to help them get well, but you knew that you probably wouldn't be able to. It was just wonderful to see the humanness of the individual who had been in high positions.

MAJ Gurney: I have been enamored with that question because as I have read the history, and have looked at all of our papers and correspondence of the period, I had the feeling just by seeing how her memory is treated in history, that there was something special about this woman. She was just universally well loved. You can feel that even in the papers.

BG Dunlap: She was little in stature. So she was known as "the little colonel."
(Laughter)

They tell of how, after she retired, she was seen going up the steps at the Capitol with that briefcase and into the offices of the different committees, still fighting for the Army Nurse Corps. They all knew her. I had not met her until she was a patient. So, these feelings I have for her came out of my respect and admiration for her as such an important part of the history of the Corps. We recognized what she had done for our Corps. But I did not really get an opportunity to know her as a human being until I actually met her in the hospital, and it was only a short time that we had her. She was in twice. The last time, she was in intensive care. That episode was kind of tortuous to have to put her through some of the things that we put people through in intensive care.

We've identified people like that. To me, Colonel Short is the same thing. Why is it? At age 92 she enjoys life so much and gives so much to ANC History Day [event at the Academy of Health Sciences] by being there.

That little Captain Johnson came up to her yesterday—I don't think you were there at the time—and Colonel Short had just said something, and she said, "May I ask you a personal question?" And Colonel Short said, "Sure." "Is the rumor about your age really true?" And Colonel Short said, "I'm 92 and a half years, if that's what the rumor is."

It's that certain quality you see in some people. I think this was in the relationships that Colonel Blanchfield built throughout her career. That was her, no doubt.

I see it in Colonel Short so much because this is a woman who never, never seeks or wants any recognition for what she does. She gives of herself constantly. You go out to her house and you take something thinking, "Well, I'm going to take Colonel Short this or that." You cannot get ahead of that woman. H. R. [Hattie R. Brantley] and I went out there Sunday to take the stamps from Mary [Burroughs] and to leave the punch cup that Colonel Short left to Carolyn Barr. At church, as we went in, we had each been given a carnation, kind of an orange-colored carnation. I said, "I'm not a mother." They insisted I got one. So, we said,

“We’re going to give these to Colonel Short and Mary.” We brought them each a carnation. Don’t you know, before we could leave, Colonel Short goes and picks up a plastic bag with some silk flowers in it and wants to know if I could use those at the cemetery. I was going out to put flowers at the graveside. I keep them at her sister’s and brother-in-law’s and nephew’s graves. I took them because I can use them later on, not for that occasion. But every time I go out there, I don’t care when it is, I try to think maybe I can give something to her, but I end up receiving from her much more than I can give to her.

MAJ Gurney: Oh, dear. And that was the same with Colonel Blanchfield?

BG Dunlap: It must have been.

SELECTION FOR CHIEF, ARMY NURSE CORPS

We all knew that the next Chief of the Army Nurse Corps was going to be selected. We didn’t know how it was going to happen. One Saturday, I was attending the luncheon for the Army School of Nursing Alumni. It was their fiftieth, I think. It was going to be their last one because they realized that they were getting along in age. Their numbers were decreasing. It was becoming more difficult for them to have this type of reunion. It was an emotional thing held at the officers’ club at Walter Reed. I received a phone call from General Hays saying “Lil, you’re to be in General [William C.] Westmoreland’s office on Monday. And I don’t know what it’s all about. But don’t tell anybody.” (Laughter)

Well, I thought to myself, I wonder what’s happened? I knew it had to be something to do with that. I said to myself, had they selected some people? Am I being one of those that he’s interviewing as a possibility? I didn’t know. All week-end now, I had to think about this.

MAJ Gurney: Oh, my dear!

BG Dunlap: Don’t say anything. (Laughter) Don’t say anything. I went on duty at Walter Reed Monday morning. I was to be over there at General Westmoreland’s office at eleven o’clock. So, I went on duty. I took my greens in that morning. That morning was the morning that the IG [Inspector General] team was coming out to Walter Reed to conduct the entrance interview and to start its inspection. I had to get Mary McHugh, the assistant, to go up to that instead of me. But yet, I couldn’t tell Mary why I had to be absent. I said I had a call from The Surgeon General’s Office. You know how it is when The Surgeon General’s Office wants you, you go. So, I’ll be going down. I said, “I’ll be going.” I didn’t say where.

I changed into the green uniform and went across the river to the Pentagon. I sat there for awhile in the little anteroom to General Westmoreland’s office. It was just a little passageway and had a bench on this side and a bench on the other side. (Laughter)

I sat there. My feet couldn't touch the floor the benches were so high. In a little bit they called me and I went in. I did not know General Westmoreland. I had not served with him. He had a little sitting area. He got up from his desk and we went over and sat in the little sitting area. We talked a little bit socially, about my career and things like that, but not a real probing conversation. Then I left. When I did I thought, "Well, what's that all about?" (Laughter)

I still couldn't say anything. So I went back on duty. I can't remember if it was a week, or two weeks, but I got a phone call from the General Officer Branch to report over to General Westmoreland's office. This was like four-thirty or five o'clock in the afternoon. So, I went over there.

MAJ Gurney: In whites? Or, did you have greens?

BG Dunlap: No, in greens.

MAJ Gurney: Did you have to go home to get your greens? Or did you have them with you?

BG Dunlap: No. I took them in with me. (Laughter) I learned. I got over there and sat on that little bench again. It was too tall for me. [Lieutenant] General Walter T. Kerwin came in. He was DCSPER [Deputy Chief of Staff for Personnel]. He came in and said "hello." He sat over on the other bench. He had big notebooks with him. They were huge—Army Regulations. I didn't know what they were. I thought, well, if he has to see him too, I'll never get in to see him. (Laughter)

I waited. Finally, the door opened. They invited General Kerwin and myself to come in. We went in and sat in a little corner. General Westmoreland introduced us. He said he had asked General Kerwin to be there. General Westmoreland advised me that I had been selected to be the next Chief of the Army Nurse Corps and had been selected to be promoted to general officer. He advised me not to say anything about it because it had to be confirmed by the Senate. He did not know how President [Richard M.] Nixon wanted to handle this. He knew how President [Lyndon B.] Johnson liked to handle the announcement of general officer promotions, but he didn't know what President Nixon wanted to do. He said, "Do you have any enemies in Congress?" (Laughter)

I said, "They don't even know who I am." Then, he brought up something that is not known by many people in the AMEDD and certainly was not known until after I became Chief of the Corps. He said that he wanted me to agree to be Chief Nurse for a term of two years. I'm trying to think was it two years? It seems like it was two years. By law, the Chief will not serve more than four years. He was asking that of General Bailey also, who became Director of the WACs. He wanted us to agree that at the end of the two years we would apply for retirement. At that time, I had twenty-eight years' service. I was into the twenty-ninth by then. I never knew just exactly what was behind all of this, other than I felt that it had to do with that, my number of years of service. But I was an unusual case. I don't know if I discussed this before. I think I discussed my move into the Regular

Army. My Regular Army permanent date of rank was six years after I came on active duty, rather than at the time of my entry on active duty. My Regular Army date of entry was 1949 instead of 1942. If you add thirty years to '49, that meant that I could stay until '79 before I'd have mandatory retirement based on my Regular Army date of service. That would certainly put me beyond the statutory four-year term as Chief. (Laughter)

That'd be like General MacArthur and Lil staying on so long. (Laughter)

I think that probably had something to do with it. In my mind, I questioned it. But I thought, how could I say, "No. I won't do it." It was an opportunity to be able to be Chief of the Corps and a general officer, even if it were just two years. So I signed the statement. That's why General Kerwin was there. He was to show the legal opinions and whether they had the authority to do that. The appointment as Chief was not for four years. It was at the pleasure of the Secretary of the Army or President of the United States, or something like that. So, I signed it. But I still could not tell anyone that I was going to be the next Chief and a general.

It was shortly after that that I came down to Dallas to that NLN convention. I couldn't tell anybody. I had kinfolks in Fort Worth. Plus, I knew all these Texas nurses. Many of them were national leaders. I had served on national committees with them. I thought wouldn't it be tremendous if it were announced in Dallas while I'm down here. But there was no way that I could tell anybody. I returned to Walter Reed. In addition to General Blanchfield's hospitalization, Secretary [Melvin] Laird, our Secretary of Defense, was a patient on Ward 8 at Walter Reed. He had sent for me the day before I got back. So, when I returned, they said, "He wants to see you." I thought, oh boy. I'm going to get stonewalled on Ward 8. (Laughter)

When I got up there, he was ambulatory. He said, "I'm getting ready to send your recommendation for promotion over to the Congress." He said, "I thought you might like to see it." I'll never forget that. He really was really so personal. It meant so much to me. He sat me down and wanted to know if I wanted a cup of coffee. I never drank the stuff. But he wanted me to see him sign it. Then, it was to go to the Congress. I still couldn't tell anybody. (Laughter)

I was so naive. I said, "What happens now?" (Laughter)

He explained to me it goes to the Congress. Congress usually considers all of the promotions on a certain day of each week. It would probably be considered on that day. After it was considered and it passed, then they'd make arrangements for the announcement to be made. Therefore, I didn't really know when the Congress was going to consider it. About four o'clock one afternoon I was standing at my desk. I had just come in from making rounds. I was at the "in" box going through the papers and saying I'll never get through this "in" box. About that time [Lieutenant] General [Hal] Jennings, The Surgeon General, walked in. He says, "Well, you better get through it in at least five minutes. Because in five minutes they're going to announce that you have been selected to be Chief of the Corps and promoted." He wanted to be the first to congratulate me. The announcement was to be made by Major General Colin F. Vorder Bruegge at WRAMC because that was the headquarters there. General Jennings wasn't going to be there. He was

going on home. But he congratulated me. About that time the phone started ringing from WRAMC. It was Brigadier General William H. Meroney who had called down to say that General Vorder Bruegge was having a staff meeting and he wanted me up there. I said, "Yes, sir. I'll be there." I knew what was going to happen. General Meroney wasn't sure, but he had noted The Surgeon General was going to come in. He knew the announcement was going to be made up there. I always had a clean white uniform hanging behind the screens so I took time to put on that clean white uniform to go up there. Another phone call came down. "They're waiting up here." (Laughter)

We were playing cat and mouse. I knew what was going to happen. They didn't know I knew what was going to happen. My secretary said, "She's on her way." I got out into the main corridor. A former patient stopped me and wanted to thank me for the care that he had received there. I couldn't say, "I'm sorry. You can't talk to me." (Laughter)

About that time here came my NCOIC. "They called down and they want you up at that meeting right now." (Laughter) I say "up" because it was up the hill to WRAMC headquarters.

MAJ Gurney: WRAMC headquarters was not in the hospital?

BG Dunlap: You know where WRAIR is? It's across from AFIP [Armed Forces Institute of Pathology]. The WRAMC headquarters was up there near those buildings. So, I got myself up there. (Laughter)

I walked in and, of course, the WRAMC headquarters staff was all sitting around the tables where we usually sat. At that time, then, General Vorder Bruegge made the official announcement of the selection. Then it was released nationwide, worldwide really. I had broken not telling anyone a couple of days [before], after Secretary Laird told me that he was signing the papers. I told Carolyn, my sister. I knew it was getting ready to happen. I was concerned about my father. He was a very emotional, sentimental person. I was afraid that once it was announced the press in San Antonio would descend on him. So I told Carolyn. I said, "Carolyn, when it's announced you have to be sure that Tom Matthews, who was PAO [public affairs officer] at BAMC, fields all the questions and that you protect Daddy." (Laughter)

I didn't want them to turn him into a basket case at that point. So, she knew just a couple of days before I thought it was going to happen. The minute it was announced and the announcement came in to BAMC, Tom Matthews got involved and Carolyn was involved in it. They did protect Daddy by trying to get the phone calls directed to the Command Information Office. I was also getting phone calls from all over the world at that point. For two weeks we didn't get anything done in nursing service there. The secretary said, "We sure had a good time for two weeks but we haven't done much nursing. Have we?" (Laughter)

I got a phone call from two Air Force officers who were my classmates in hospital administration. Both of them were at Randolph. One of them, [Lieutenant Colonel] Don Wagoner, became chief of the Air Force MSCs. They called to con-

gratulate me and to tell me they sure were glad that they helped me get through statistics. I never would've made it without them. (Laughter)

That was a joke because I was helping them through it. (Laughter)

My sister's husband was stationed at Clark Air Force Base. I had a call come in from the Philippines. People were stopping by the office all the time. It was a tremendous experience at Walter Reed. Everybody got excited. They were excited I was going to be leaving, you know. (Laughter)

MAJ Gurney: Why? (Laughter)

BG Dunlap: They were going to get rid of this chief nurse.

That's how the announcement that I was to be the next Chief of the Army Nurse Corps and a general officer was made. Before I left Walter Reed, I received a phone call from the General Officer Section, a warrant officer. He wanted to come out and brief me on what I was entitled to as a general officer in terms of stationery, flags, and all those things. In his comment, he started telling me, by regulation, what I was entitled to. I was laughing to myself—a flag for my boat! (Laughter)

I was entitled to the beautiful pistol belt, and the .45 [caliber pistol]. He felt sure that I probably didn't want the 45. I said, "Oh, yes. I do, but not a 45. How about a 38?" Immediately it came to me that he was very sincere, thinking a woman officer would never wear the pistol belt, and would probably never wear it with the pistol, especially a nurse. I thought to myself, "Just because I'm a woman, they're thinking I don't want the same things as all the other generals. She's different, they say." I said "Oh, no. I'd like to have all of the things that a general officer is entitled to. If they're nice." So, he came out in a few days, and he brought me the flags and the stationery and different things like that. He brought me my pistol belt. It was a beautiful belt. He brought the 38 in all its wrappings. After he left I put that belt and holster on over my white uniform. I put the pistol down in it, and it was still in its wrappings. I walked to the door of the office and said to my secretary, "Ada." She turned around. "Yes, Colonel." I took the pistol out and I said, "Now, we'll get some action around here." (Laughter)

You could've heard her laugh all over Walter Reed. (Laughter)

I just feel I want to share these things with you. You can decide whether you want to put that in history—it's immaterial to me. But, to me, this is part of the human side of it.

MAJ Gurney: That's right. That's absolutely right.

BG Dunlap: I also want to point out that even though the general is a woman, she's entitled to these things. So she should have them, even though she probably doesn't want them. This is something that I felt throughout my time as a general officer. I wanted everything that I was entitled to, but I also wanted the responsibilities that went along with it. This little step was the beginning.

I stayed on at Walter Reed. I had to go to the general officer "charm school." (Laughter) Those who have been selected to be general officer had to go through

the charm course at the Pentagon before we were general officers. It was interesting to meet with the others who'd been selected to be generals. Inez Bailey, who was the Director of the WACs was there, too.

MAJ Gurney: How did you feel? Other than being leery of preconceptions about women general officers, what other feelings were going through your mind? What did you think about your new responsibility?

BG Dunlap: I had a big job ahead of me. (Laughter)

But I had served in The Surgeon General's Office before. The Chief of the Army Nurse Corps is the top job in the Army Nurse Corps. But the chief of the Assignment Branch really is involved with personnel assignments, career planning, and the education of trainees. That's the leader (laughter) of the whole Army Nurse Corps. I had served in that office. I felt I could do the job.

I think I've told you before. I had a basic self-confidence about any of the jobs I went into. I could do things. Certainly I had some concerns and apprehensions (laughter) about what it would entail. But there was never a thought in my mind that I couldn't do the job. I was honored to be selected and looking forward to do it. I realized that I would be the second general in only the second year of having a general officer as Chief. Anna Mae was a general as Chief for only one year. The role still had not been clearly defined. I wondered what the level of acceptance was. When you're in your little ol' medical field, everyone's all excited and you're one of the family, like the excitement at Walter Reed. That's one thing. But when you're relating to the rest of the Army, that was something else. I knew I'd have to develop that.

After all the excitement died down, we then had a farewell party. I went to The Surgeon General's Office about fifteen days before I was to be sworn in. One of the last things that the administrative assistant said to me as he helped me carry my things out of the office and put them in my car—I had a little Buick then—he said to me, "Colonel? Are you going to get yourself a Cadillac?" I said, "No. Why?" He said, "The other Chief of the Corps is a general and she has a Cadillac." I said, "No way. I'm keeping my Buick." (Laughter)

I think I disappointed him that I wasn't going to drive a Cadillac now that I was going to be a general officer. (Laughter)

Unfinished Business

ARMY NURSE CORPS ORIENTATION PROGRAM

MAJ Gurney: When you were First Army chief nurse, there were some events and some activities going on at Fort Knox that you wanted to talk about. One was orientation of nurses to the Army before they deployed to Vietnam.

BG Dunlap: Yes. This was a program developed based on our informal evaluation of the effectiveness of the Army Nurses who were going to Vietnam. Recall that

their tour was only one year. At that time, Army Nurses could volunteer to come into the Army with a guaranteed assignment to Vietnam. We felt that nurses coming in from civilian nursing came with varying levels [of] experience, and most of them with no experience in trauma nursing, especially trauma of the type that you might get in emergency rooms or in a big teaching hospital. Then we were sending them to Vietnam, where a good deal of their nursing was going to be trauma nursing, something they may not be prepared to jump into that quickly.

Secondly, they had not functioned in an Army hospital. Their only orientation to the AMEDD team was through their orientation course here at Fort Sam Houston. That's very limited. It's only theory, not an actual working environment. We felt that we should provide some type of orientation tour prior to deploying them to Vietnam. Most of these young people signed up with a two-year obligation. If you do the math, they had a six- or eight-week orientation or basic. There was always pressure to decrease it. Then, if we had a six-month orientation program at one of our medical facilities, followed by a year in Vietnam, it would almost be time for them to get out of the service when they returned. Many of them extended to stay on.

We were able to set up some of these programs. I particularly remember the program at Fort Knox because I was chief nurse of First Army at the time. I worked closely with Fort Knox. [Colonel] Barbara Kishpaugh was chief nurse there. They set up a tremendous program for those young nurses so they were rotated, particularly through the emergency room, the surgical areas, and the intensive and coronary care areas. They were rotated anywhere they thought they could be prepared for what they'd be exposed to in Vietnam. You really can't get the impact of serving in a combat area, even in the emergency room at Walter Reed. It's just different. As we all know, you don't suddenly say, "Well, there's been a military action up the road apiece and here come the choppers with all the casualties." One chopper may come in at Brooke bringing in casualties from an automobile accident. Or EMS [emergency medical service] may come in. But that's different than having choppers landing, just one right after the other, bringing patients.

That was the purpose of setting up the orientation for nurses who had volunteered with guaranteed assignments to Vietnam. It was to at least give as much orientation as we could in preparation for putting them in that totally different environment. They'd be there for one year. Then they'd either stay on with us when they came back or get out of the service.

MAJ Gurney: Did you get feedback from the nurses themselves that validated the program? What did they say about it?

BG Dunlap: They felt it was very valuable to them. I wish I could remember the hospitals where we had these programs set up. But I can't. A lot depended on the hospital and the program. It really was up to the chief nurse at that hospital to set up the content of the program. We did not direct the content of the program but, rather, the whole purpose of the program, and then they developed the program.

It's like anything else; often the quality of that type of program depends on those who conduct the program.

But yes, we felt that it was well worthwhile for us to do it. I can't help but reflect back to World War II. We went overseas without basic training. We heard yesterday about all those many who did not have basic training and were not prepared to go into a combat environment. As a result of that need, they then set up a nurse basic training later in World War II to at least provide some basic preparation for the nurses who would be going into combat areas. At that time they were being prepared to go into a combat area for an indefinite period of time whereas in Vietnam we knew it was for one year. We really had to think in terms of how much we could give them to prepare them to really be effective and a contributing member of the health care team. They would be assuming such great responsibilities, perhaps being the only nurse on that ward.

CHIEF NURSE "LESSONS LEARNED"

I thought the program was very successful. Another program that started before I moved into The Surgeon General's Office continued after I became Chief. Commanders returning from Vietnam would have "lessons learned" sessions in The Surgeon General's Office. I felt very strongly about having chief nurses from Vietnam, particularly the chief nurse of Vietnam, come in for several days with us for "lessons learned" sessions. Are those documented in the historical file?

MAJ Gurney: They're incorporated into the Oral History Program. We have an extensive one from Jeannie Caylor.

BG Dunlap: Good. Nellie Henley? Pat Murphy?

MAJ Gurney: Yes. They're all included as oral histories.

BG Dunlap: [Colonel] Marion Minter? She was our last chief nurse in Vietnam. After we get on into my tour as Chief, I depended on those so much, the "lessons learned" from those chief nurses. We used them in considering whether to change or continue policies for Army Nurse Corps assignments over there.

SUBSTANCE ABUSE IN VIETNAM

You were going to ask me a question about substance abuse over there. I have been questioned in retirement about whether we had a problem with Army Nurses and substance abuse. I said, "Not to my knowledge." I depended so much on these "lessons learned" briefings that we had.

I think I'll just end with a little philosophy, which I seem to have a lot of. (Laughter) But that's a privilege of being a senior citizen.

We talk about the mission of the Army Medical Department and the Army. It's military. During peace, our job is to prepare for war. So, in peacetime we're

training, educating, preparing for the time when we have a war. That's something we must do. But then, we must also remember that certainly in my lifetime, no matter how much we have prepared the people who are in the service, we are still going to have large numbers of people coming into service from the civilian community with all different levels of experience and preparation. We have to come up at the time with some type of program to fit them in so they can be effective immediately. We don't have long periods of time for them to learn what they're going to have to be doing. As we learn more and more about the future wars to be fought, and the swiftness of them, that's going to be even more important to us.

We can't afford to have a unit "staging"—the term we used during World War II—for months before being shipped to respond in some area with the missiles and nuclear weapons and whatnot that we have now. We're not going to enjoy that luxury, if you can refer to it as a luxury, that we had as units in World War II. At that time the units may have functioned as units and trained some as units, prior to actually going into the combat area.

MAJ Gurney: As you did in California and then in Arkansas?

BG Dunlap: Some of the other units did, too. As an example, I was a brand-new graduate. I had been on duty at Brooke, in the hospital setting, from November until the 1st of March, before joining the unit. So, at least I'd had a few months working in an Army hospital. I was learning something about the Army, but certainly not combat nursing. We're going to be bringing new graduates in with limited clinical experience. We'll be bringing people in from the Army Reserve, the National Guard. Their active participation in nursing and civilian life varies so much. It really requires great skill and dedication from the leaders of the active duty Army to mold those young officers into very effective health care teams at all levels.

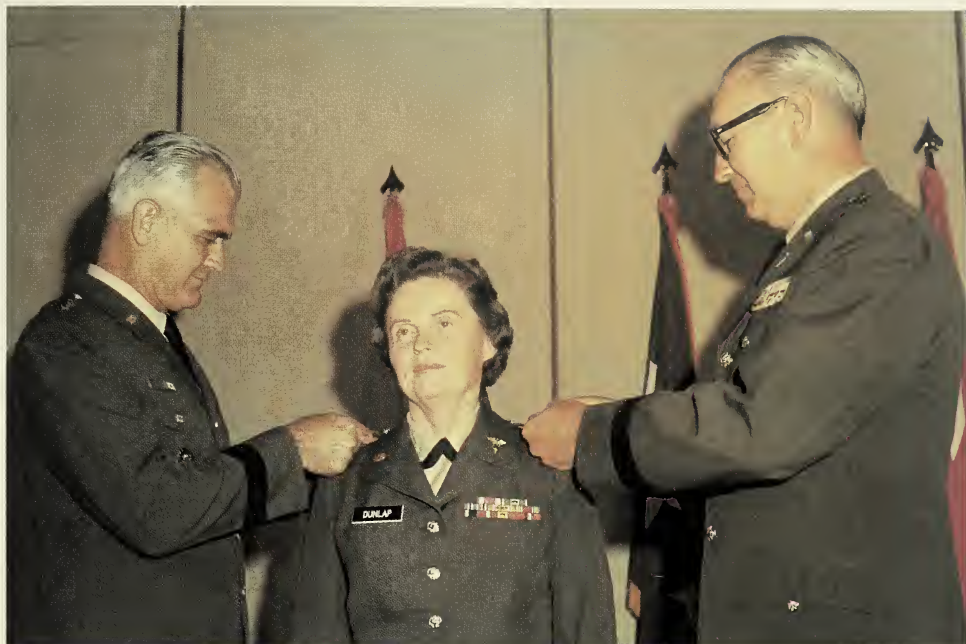
Now, I'll get off that philosophy and move on to another one.

MAJ Gurney: Tell me about the incident of the tornado at Fort Knox.

BG Dunlap: What's that little ol' town right outside of Fort Knox? (Laughter)

I want to say Bardstown or something like that. (Laughter) There's a small town outside the post at Fort Knox. A tornado had ripped through there with a number of casualties. This was an opportunity for the hospital to practice the emergency operations plan. These are the procedures that every hospital is supposed to have and use in practice sessions. They need to determine how realistic they are. Sometimes units get a little bit lax about going through them as they should. When this actually happened, it gave the staff at Fort Knox the firsthand experience of responding. I was so proud of the nursing team there. They had many civilian nurses, nursing assistants, and military nursing service personnel living on post. It seemed that the nursing service personnel responded quicker and in greater numbers, getting on duty. Those on duty stayed on duty to help take care of the emergency as it came. I'm sure that must be documented someplace in a report from Fort Knox. I would think it might be.

This demonstrated my role as chief nurse of First Army. Barbara [Kishpaugh] kept me informed about what was happening. I could keep the Surgeon of the First Army informed better than what information he was getting. The information that was coming in using our informal channels was more effective. I kept in contact to determine if we needed to supplement the nursing personnel without having to wait for a decision to be made at all the different levels here. I knew more quickly what personnel and how many we might have needed down there to help them. First Army could respond more quickly to get the people there when they were needed.



General William C. Westmoreland, left, Army Chief of Staff, and Lt. Gen. Hal B. Jennings, Army Surgeon General, pin the insignia of rank on Brig. Gen. Lillian Dunlap, September 1971; below, Generals Westmoreland and Jennings celebrate with, left to right, Carolyn and Chip Putnam and Lucile, Ira, and Lillian Dunlap. [U.S. Army photos]





Brig. Gen. Lillian Dunlap reviewing the Honor Guard with Maj. Gen. Orwin C. Talbott, Commander, Fort Benning, Georgia, June 1972. This visit coincided with the opening of the Army Nurse Corps' first nurse practitioner training program at Fort Benning; below, General Dunlap, front row, center, and senior nursing leaders during the annual Chief Nurse Conference, Washington, D.C., 1974. [U.S. Army photos]





Guest speaker at the dedication of the new building for Incarnate Word's School of Nursing [Incarnate Word College photo]



Visiting with a patient at the 279th Station Hospital, Stuttgart, Germany, May 1972; below, with Col. Sara Lundy, Chief, Department of Nursing, Brooke Army Medical Center, and a patient at the center, November 1974. [U.S. Army photos]





Six former and current Chiefs of the Army Nurse Corps gathered for the Corps' 75th Anniversary. The Surgeon General took this occasion to thank them for their valuable contributions. Clockwise from far left, Brig. Gen. (Ret.) Anna Mae Hays, Col. (Ret.) Margaret Harper, Lt. Gen. Richard Taylor, Col. (Ret.) Mildred Irene Clark, Brig. Gen. Lillian Dunlap, Col. (Ret.) Inez Haynes, and Col. (Ret.) Ruby Bryant. [U.S. Army photo]



On the occasion of his retirement from public service, Secretary of Defense Melvin Laird, who oversaw the development of the first corps of women generals, gathered the military services' current and past generals for a fond farewell. With him, left to right, are Brig. Gen. (Ret.) Anna Mae Hays, Brig. Gen. Lillian Dunlap, Maj. Gen. Jeanne Holm (USAF), Brig. Gen. Mildred Inez Bailey, Brig. Gen. (Ret.) Elizabeth Hoisington, Brig. Gen. Ann Hefley (USAF), and Rear Adm. Alene B. Duerk (USN). [Department of Defense photo]



*The Commander,
Military District of
Washington,
presents Brig. Gen.
Lillian Dunlap with
her retirement
papers; left, retiring
officers "troop the
line" on the parade
field at Fort Myer,
Virginia, August
1975. [U.S. Army
photos]*



*Then-Col. Madelyn
 Parks, left, incoming
 Chief, Army Nurse
 Corps, and Sister Theresa
 Stanley join General
 Dunlap at her farewell
 gala, August 1975
 [Personal photo]; right,
 this official portrait hung
 at Delano Hall, Walter
 Reed Institute of Nursing,
 until it closed
 in 1978. [Brooks
 Photographers]*





Brig. Gen. (Ret.) Lillian Dunlap, Maj. Gen. (Ret.) Spurgeon Neel, and Lt. Gen. Quinn Becker, The Surgeon General, break ground for Phase I of the Army Medical Department Museum, Fort Sam Houston, Texas, May 1988; below, the City of San Antonio recognized General Dunlap's substantial contribution to the community by dedicating a barge in her honor at the city's Riverwalk, February 1999.
 [Dreamland Photography, Inc.]



Chief, Army Nurse Corps

Transition to the Role as Chief

MAJ Gurney: Perhaps we can discuss, now, your transition into the Chief's role. Did you have any preparation? What did they do to prepare you to take on that role?

BG Dunlap: I think I mentioned earlier that preparation for me to become Chief of the Army Nurse Corps was not formal. I was brought into the office two weeks prior to the time that I was to become Chief of the Corps. But, considering the activities the outgoing Chief was involved in, she really doesn't have much time in the last two weeks to be with the incoming Chief to go over all the pending actions in any depth. Having been in The Surgeon General's Office from '66 to '68 as chief of the Army Nurse Corps Assignment Branch, and having been out at First Army headquarters for three years, because I was up that near the flagpole, I was more aware of what's going on than if I were a great distance away. I was able to attend some of the conferences that the chief nurse had that normally others wouldn't have the opportunity to attend. I'd been chief nurse at Walter Reed where I had contact with WRAIR and with WRAIN. I think that was my preparation for going into the role of Chief of the Army Nurse Corps. There was no formal orientation as such.

MAJ Gurney: Did they conduct a series of briefings to bring you up to date on, say, the Career Activities Branch or the historical program or research? I would picture a lot of briefings with updates.

BG Dunlap: During the two weeks I was there in the office I did have an opportunity to get to the different sections. Remember, The Surgeon General's Office was organized differently then.

MAJ Gurney: How was it organized?

BG Dunlap: I'm trying to think. I don't think we had an AMEDD PERSA [Personnel Activity] then. When did AMEDD PERSA become organized? I think I've seen reports on the reorganization of the Office of The Surgeon General so we could validate by the record when that happened.

MAJ Gurney: Did they used to come under the chief nurse?

BG Dunlap: No. It was under personnel. When I was in there I was directly under the director of Personnel. But the relationship with the Chief of the Army Nurse

Corps was a much stronger relationship. It was almost a dual relationship with the director of Personnel and the Chief of the Army Nurse Corps. As AMEDD personnel developed and different policies were established, efforts were made to decrease the strength of the relationship between the Corps Chief and the Career Activities Branch of that particular Corps—putting it tactfully. (Laughter)

During those two weeks I was able to get around to the different sections, divisions, branches, and whatnot—to meet the people and find out as much as I felt I needed to know for a jumping-off place.

TEAM BUILDING

MAJ Gurney: Who was the assistant chief of the Army Nurse Corps at that time?

BG Dunlap: The assistant chief of the Army Nurse Corps was Colonel Louise Rosasco. She was one of our true nursing leaders. She had been promoted to full colonel early, and the regulations at that time were that you had to retire after so many years' time in grade. That may come before the thirty years' or twenty-eight years' time in service. Unfortunately, her years in grade came up before her years of service. I think it was just a short time. That's a technicality you might want to check into. She had a mandatory retirement in December of '71. I was sworn in as Chief in September of '71 so we had very little time together. When I go through who the assistant chiefs I worked with were, well, you're going to see I had more assistant chiefs than anyone else and people would say, "You sure must've been hard to get along with." (Laughter)

But Louise was the assistant chief from September until December when she had mandatory retirement. She really did not want to retire. She wanted to continue in her career in the Army Nurse Corps. But because of the law she had mandatory retirement.

At the time I was sworn in as Chief, we also had an administrative assistant to the Chief, Army Nurse Corps. It was a position that General Hays had created, and Colonel Sue Frazier was the administrative assistant to the Chief of the Army Nurse Corps. Sue had managed her own staff, and I found out when I came in she had been selected to go to the Army War College. So I knew that she would be leaving the next year to go to the War College. I had a secretary whose method of operation was quite different than I expected of a secretary. Her professionalism was less than I expected of a secretary for the Chief of the Army Nurse Corps. Remember the period of time here. I could not see the secretary to the Chief of the Army Nurse Corps coming to work dressed in slacks and "hippie" gear. I'm an old "fuddy-duddy" but to me it was "hippie" gear. I thought that she should have a certain amount of dignity in the Office of the Chief because you have people from the military and civilian communities coming into that office.

When I took a look at the staff I had, I knew that they were good people. They certainly had met the expectations of the outgoing Chief. But each of us function differently. To me, this is one of the basic lessons I learned. In administration, you don't want people that are "yes" people. You want people who will be candid, who

have a great deal of integrity. They will find out for you everything they can. They will let you know. When they don't agree with you, they'll let you know what their view is, and why. You have to be willing to be flexible enough to accept recommendations. If you don't accept recommendations, and you insist on your way, you're ultimately responsible for the decision. Whether you've accepted input from others or made the decision yourself, once that decision is made then you have to feel that you have the support of your staff.

I have discussed that with you before [in] my role as chief of the Army Nurse Corps Assignment Branch. I felt at that level also, if the individual cannot support the Chief who has responsibility for the final decision, then that individual has to do a little soul-searching and ask for reassignment or be willing to accept, not agree always, but accept. They should be loyal in implementation of the decision of the Chief.

MAJ Gurney: As you were preparing to be Chief and knew that you would have a turnover in the assistant chief, what was the selection process for the new assistant chief of the Corps?

BG Dunlap: It was in The Surgeon General's Office. The Surgeon General appointed a board. The Deputy Surgeon General chaired the board. Senior members of the AMEDD were on the board. Of course, I was on the board. We reviewed the "201 Files" of the people who were eligible. We called them "201 Files." What do you call them now?

MAJ Gurney: Still "201."

BG Dunlap: (Laughter) But they were different than the "201 Files" now. You have them all on computers, I think.

MAJ Gurney: Yes, microfiche, and the Officer Record Brief [ORB].

BG Dunlap: (Laughter) Well, we had them in old flipover type files. These files from those who were qualified were reviewed. The Chief of the Army Nurse Corps had the opportunity to provide input regarding her recommendations for an assistant chief. But it wasn't just her decision.

The board compiled a priority listing of recommendations for the Surgeon General. The Surgeon General accepted our recommendation that it be Colonel Edith Bonnet. Colonel Edith Bonnet was chief nurse in Europe at that time. Colonel Bonnet and I had first met at Brooke in 1946 as captains. We served together. Our careers had crossed off and on during the time since. We were personal friends. We had respect for each other as individuals and as professionals. Colonel Bonnet had been chief nurse of a TOE unit—training unit. She had been chief nurse of a hospital. She had been chief nurse in Japan. She had been in The Surgeon General's Office in the role of the nurse methods analyst. She was a graduate of the Army-Baylor Hospital Administration Program. And, to me, the most

important thing about Colonel Bonnet was her as a person, and her relationship with the members of the AMEDD team. I'm making a broad-sweeping statement here. When I say everybody, there's always someone who doesn't. But, when you think of the total group, I've never known anyone who knew Colonel Bonnet, who worked with her, who didn't have the greatest love and respect for her as a person and for her abilities.

This was certainly something that I felt we needed in The Surgeon General's Office from the assistant chief of the Corps—someone compatible with the Chief of the Corps, someone who knew me well enough that she could be candid with me, and would be. The assistant chief of the Corps really has to interact with the other members of The Surgeon General's Office, possibly more than the Chief of the Corps does. She's dealing with the day-to-day activities. Also, when the Chief of the Corps is out of the office, the assistant chief of the Corps is the one who really has to carry on the activities there by interacting with The Surgeon General's Office, with the other federal agencies, and with our chief nurses throughout the world. I felt that Colonel Bonnet had this ability and was such a good person—she still is. That is what we needed as the assistant chief of the Corps. This choice was approved. Our deputy surgeon general and many others knew her and had served with her and felt the same way. She was brought back from Europe and took office the 1st of January 1972.

A GRAND AND GLORIOUS OCCASION

MAJ Gurney: Let's go back to talk about your promotion ceremony. Then we can talk more about each of your assistant chiefs as we build chronologically.

BG Dunlap: They each brought different strengths to complement the Chief.

MAJ Gurney: Yes. That's important.

When you were promoted, what was the ceremony like?

BG Dunlap: Grand and glorious. (Laughter)

I am grateful to Colonel Sue Frazier for being the one who planned the ceremony. People who know Sue know everything that she does still is done with a great perfection and concern. We were in the Forrestal Building. She made arrangements for the promotion and oath of office ceremony to be held in the auditorium at the Forrestal Building. She also made arrangements for General Westmoreland, the Chief of Staff, to be there to speak and to help pin on the star. He presented me with my general officer flag. The Adjutant General of the Army, Vern Bowers, administered the oath of office. The Chief of Chaplains of the Army, General Hyatt, gave the invocation. Our DCSPER, General Kerwin, came over. I say *over* because in Washington, everything's "across the river," referring to the Pentagon. You always refer to "Well, we go across the river." Well, that's going over to the Pentagon because we were on the District side of the river.

My family, my father and two sisters and my nephew and a whole bunch of cousins, came up from Texas and Oklahoma for this. We met in General Jennings', The Surgeon General's, office. General Westmoreland was there with General and Mrs. Jennings. My family had an opportunity to meet them. They all were escorted to the auditorium. Then the platform party went to the auditorium. All of this is on tape, and I just recently reviewed a copy.

Colonel Frazier arranged to have the whole ceremony on film. Copies were made of this and sent worldwide to the Army Areas to be circulated to the hospitals in that area so that all of the Army Nurses would have the opportunity to feel that they had been part of the ceremony. To my knowledge, this was the only time this was done. In recent years, I don't know if it was or not. I'm not sure. The ceremony is a very emotional ceremony for those involved, because your family's there. I had invited all of my former chief nurses. All but one was able to make it. As I looked at them, I just couldn't help but think about each one's contribution to my career—how much they had meant to my career, and how grateful I was to each one of them. There were also members there of the AMEDD team that I had enjoyed relationships with as students, in the hospital setting, former commanders, and so forth.

It was a very emotional ceremony, possibly even more so than my retirement ceremony. That surprised me because that came out as I was recently thinking it through. Maybe it's because at the swearing-in ceremony—you don't say swearing in—at the oath of office and the promotion ceremony, you're filled with expectation and the unknown. You're a little more apprehensive about that than at retirement. At retirement, you can look back on what's been accomplished.

General Westmoreland and General Jennings pinned my stars on. They asked me, did I want my Daddy to do it? I would have loved for Daddy to do it. But I know my Daddy was a very sentimental person and he had a heart condition. I was concerned that it might have been too much for him and I didn't want that to happen. So, General Jennings and General Westmoreland pinned my stars on. General Westmoreland gave me my flag, administered my oath of office, and then I moved to the lectern to speak. I thought, "Dear Lord, be with me. (Laughter) Here we go." I made my remarks. Of course, if you review the film, you'll know that the AMEDD is the kissingest bunch. (Laughter) As I reviewed the tape the other day I thought, oh, my goodness—all the kissing that went on, as they pass by to congratulate you. (Laughter)

But I think that's really indicative of the warmth and the feeling that we have in the AMEDD for members of the AMEDD team who we have served with throughout the years. I don't think you see that, I know you don't see that, in the line. Many line people have commented to me about the difference between the relationships of the members of the AMEDD team and the line.

After the ceremony, I had a promotion party over at the Fort Myer officers' club. The next morning I had a breakfast over there for all of the out-of-town people who had come to Washington for the ceremonies.

I'm forgetting one part of what happened prior to my becoming the Chief. We have always had a party for the outgoing Chief and the incoming Chief. That has

changed over the years. In the past, usually the assistant chief of the Corps got a letter out to all the chief nurses saying that we were going to have a portrait created of the Chief. This note included that we were going to have a reception for the outgoing and incoming Chiefs to be held in Washington, usually at Walter Reed. We'd ask them for money. (Laughter)

Contributions came in from the nursing services throughout the world to pay to have the portrait painted of the Chief. Nurses always took care of themselves and setting up funds for things. These were all legal in those days. There was no question about legality of anything like that.

I want to emphasize that. I don't want to think that the Army Nurses were doing anything illegal. They were not. Also, they sent money in for the reception to be held in Washington. Many of them were able to come in. The contributions took care of the expenses and the reception was free. We collected enough monies to put on a reception like that. The outgoing and the incoming Chiefs provided a list of those they'd like to have invited to the ceremonies. Those people were always guests.

At the reception we had for General Hays and myself, there were between six and seven hundred attending. We had an official receiving line. After a while, we took a break and we had to hold up the line awhile. But we had to take a drink of ice water or a Coke, or something. I always had to keep that extra pair of shoes hidden behind the potted palm so I could switch shoes.

MAJ Gurney: Oh, my!

BG Dunlap: Really. They had a different height heel. That relaxes the feet a little bit. Then, we'd start up again. At our reception, we were in that receiving line for the whole time of the reception actually.

MAJ Gurney: Oh, my gosh!

BG Dunlap: We finished it in time to go in for the unveiling of the portrait of the Chief. This happened when I retired also and [Brigadier] General [Madelyn N.] Parks was coming in. I would like to make a comment about that. The Chief cannot be promoted until the Senate approves the nomination and [it is] signed by the President. You cannot promote the Chief early as she's going into the new office. You call it "frocking," allowing the individual to wear the rank early without pay and benefits. It really didn't make that much difference when the rank was colonel. The incoming Chief was colonel and, the outgoing Chief was colonel. But when the outgoing Chief is [brigadier] general and the incoming Chief hasn't been promoted yet, she's a colonel. There are many people who come. There's always that difference because the effective date of the promotion is around the first of September but the reception is usually before that. So, the outgoing Chief is the general. The incoming Chief is the colonel. Many people can't come for the party and stay over for the promotion and all the ceremonies. So, the friends of the incoming Chief don't get to see her as a general officer. There's great disappoint-

ment for many of her friends and some members of the family because they don't see her as a general officer.

I should say "the Chief" because some day we'll have a male Army Nurse Corps Chief, I'm sure. But that has often entered into the discussion in planning for the party, I think. Ever since we reached general officer status. I won't dwell on that. But progress always brings up new areas to explore.

MAJ Gurney: That's right, a new challenge or opportunity.

BG Dunlap: So, as I said, it was a grand and glorious occasion.

MAJ Gurney: Could you comment on what you considered the most critical issues facing the new Corps Chief?

THE ORGANIZATION OF THE OFFICE OF THE CHIEF, ARMY NURSE CORPS

BG Dunlap: Let me think in terms of some of the issues. First, let's talk about the organization of the Office of the Chief of the Army Nurse Corps and how I came up with my plan for operating it.

MAJ Gurney: Okay. That's good.

BG Dunlap: I knew there would have to be a change by December and the 1st of January. There needed to be routines that I could set up to run the office. My philosophy in any new assignment—even, I guess, when I was a head nurse—was to first try to find out what's going on and not to just go in with a hidden agenda that suddenly is thrust on everybody. Like, I'm the new boss and we're going to change things to the way I want them. Once again, this was the way I approached The Surgeon General's Office because they had an effective, efficient operation in those who preceded me. Since the people were still going to be there with me for a period of time, I wasn't going to upset any apple carts until I felt in my own mind that the apple carts needed to be shaken up a bit.

But there were certain things I wanted each morning. The assistant chief of the Corps and the chief of the Army Nurse Corps Assignment Branch were all in the same building. They were in a different wing, but were in the same building. I wanted to meet with them every morning because I felt that we could have a meeting in the morning, then—"boom"—go do our work. That was the first thing in the morning, and it was short. That gave the chief of the ANC Assignment Branch an opportunity to bring to my attention anything that she wanted to come to my attention.

This goes with the statement I made before about the relationship between the Chief of the Corps and the chief of AMEDD Personnel. If you looked at straight organizational relationships, everything the Corps branch did had to go up the chain through AMEDD personnel channels. The effort was to decrease the relationship with the Corps Chief. This was a very touchy situation. But we were

able to work with this. As you know, I had one of the best chiefs of the ANC Branch in the person of Edie Nuttall. She later became the assistant chief of the Corps. Edie Nuttall was a detail person—a very organized person. So our meetings could be very short. “This is what we plan for our day. This is what’s facing us. Fine.” Boom. We’d go do it.

As you know, once a week The Surgeon General had a meeting with his staff. I attended it as a member of his staff so those two individuals [the ANC Branch chief and the assistant Corps chief] plus our nursing consultant formed a key group.

MAJ Gurney: That’s the question I was going to ask. You did have a nursing consultant?

BG Dunlap: Yes.

MAJ Gurney: Was she included in the morning meeting?

BG Dunlap: Yes. Anything that I wanted to bring to The Surgeon General’s staff meeting, we could identify in our meetings like this. It was a way that I felt I had to function because I’m one who feels that I have to be informed. I’m a detail person and I know it. But I want to know the details so that I can make my decisions or recommendations. I didn’t want to approach anything not prepared. So, this way I felt that I was prepared. Just like in the hospital you have change-of-shift report in the morning.

I always came into the office early. In Washington you have to beat the traffic. The time that I had before the rest of the staff arrived was very important to me because I could go through my in box and make my notes. Everybody who works in The Surgeon General’s Office, I think, takes a briefcase home—probably that’s true of the whole Washington area. My secretary used to hate to come to work because her in box would be full and mine would be empty. (Laughter)

I liked that quiet time so that I could plan my day, get the pending things as far as the in box emptied, if possible, and make notes for my secretary so that when she came in, she could get going. We’d have the meeting there, in the Chief Nurse’s Office. Then everyone went back to their daily activities.

Nurse Corps Issues

THE ARMY NURSE CLINICIAN PROGRAM

You asked about the problems. Let’s not call them problems. Let’s call them the pending actions that I faced when I entered the office. The greatest I think, was the ANCP [Army Nurse Clinician Program]. It was the 22nd of February 1971 when General Hays formed a task force of Army Nurse Corps officers and civilian consultants and brought them to The Surgeon General’s Office for several days. They really took a look at Army nursing, where we were, and where we

thought we should be going. I was not in that group. These were our clinical consultants. It was gratifying to me that when I was chief of the Assignment Branch, I had some role in helping set up the program to have consultants in Army nursing in more fields than just in anesthesia. These additional areas included such areas as Army health nursing. They had worked diligently together to come up with a design for the future of Army nursing. They called it the Army Nurse Corps Contemporary Practice Program. First of all, the name hit me. That's too much. (Laughter)

Even when you go with abbreviations—ANCCPP—you know. We have a tendency to abbreviate it to something like that. This group had identified a program. And it was really to establish a nurse clinician role for Army nurses.

MAJ Gurney: What was the motivation for this program?

BG Dunlap: General Hays, as you know, was very innovative. She felt that it was time to take a look and see, what are we doing now? What direction should the Army Nurse Corps go? By utilizing her military and civilian consultants, they came up with this design. This is the ticklish part but I have to tell it as it is. I found when I came into The Surgeon General's Office that although it was something that had been accepted by the nurses who had designed this program and decided this was the way of the future, it had not been presented to our Surgeon General for his approval. Nor had it been funded. It had kind of been done independently. The whole idea was to develop our own courses to prepare our nurse clinicians in ambulatory care, OB/GYN, pediatric, the different clinician areas. If we were going to put this program into action, including the courses, we were going to have to develop our own courses and our instructors at our Army hospitals.

The plan was to have those courses going by the next year. This is September now. You know how long it takes to develop curricula.

MAJ Gurney: Excuse me, again. Why did they decide that the nurse clinician was the way to go? What made them decide that this was the solution to our movement into the future?

BG Dunlap: Do you remember the terminology "the expanded role" in the context of nursing? The nursing profession has been looking at the role of nursing for years. Asking, which way are we going? I think this was a look paralleling that examination by the profession. It was advanced thinking in our nursing profession about the expanded role. At that time there was a shortage of doctors, plus another program was developing at the same time, which was our Physician Assistant Program. Also the AMSCs [Army Medical Specialist Corps] were also looking at trying to define an expanded role for themselves. This was a manifestation of the expanded role of nursing.

We were faced, first of all, with getting the approval of The Surgeon General and his staff for the whole program. It had to be budgeted. Sites for all the cours-

es had to be selected, and that would need coordination with hospital and post commanders. We would also have to select the faculty and they would have to develop the curriculum before we could put the program into operation.

MAJ Gurney: Then, also, you would have to develop the role that they would carry when they did go into practice?

BG Dunlap: That all was in development of the program. And that was the main thing. To assure acceptance of them once they got into practice. This all had to be built into all of the discussions. But laying the groundwork for the acceptance really didn't come at that point. Our first objective was to get acceptance at The Surgeon General's level.

The first one established was in ambulatory care at Fort Benning, Georgia. The staff there—the faculty—worked with the commander and the chief nurse to identify roles and how the students would get their clinical experience in the hospital setting. That was an added responsibility for them as opposed to someone who goes in to teach in a program where these roles are already identified.

MAJ Gurney: That's right.

BG Dunlap: They did a tremendous job, the people in The Surgeon General's Office, like Colonel Sally Travers, who was our nursing consultant. Other consultants included: Ira P. Gunn in anesthesia, Mary Mulqueen in OB/GYN and later nurse midwifery, Billie Jean Barcus in the med-surg area, and Madge Bader. I was going to say "Mim." I knew that wasn't right; Madge Bader in psychiatry.

These people worked over and beyond the call of duty—night and day—in developing these things. Then, Edie Nuttall in the Branch identified people who could be instructors in the courses. If possible, I wanted to have all of our instructors prepared at the master's level. I did not want our nurse clinician programs to be OJT [on-the-job training] programs. This philosophy differed from the Air Force. I felt very strongly that the basic educational preparation of the Army Nurse Corps officer should be a baccalaureate degree and that specialization within nursing should be at the graduate level. Although it was progressive at that time, based on the educational system, I felt it was what we needed if we continued to be the leader in military nursing education. To continue having nurses without undergraduate degrees was not in our best interests. We had nurses who were taking the operating room nursing course, the anesthesia course, psychiatry, any of these courses that we've had over the years were developed in the late '40s. We should push for them to get their undergraduate degrees or at least have some credit toward their undergraduate degrees. These nurse clinician programs should move them toward their graduate degrees. So, this is why we would have to have faculty prepared at that level. We didn't have enough that we could have everybody prepared at that level. But everybody had at least their undergraduate degree. The leaders had to have their master's degrees.

That was our goal in setting up the programs.

MAJ Gurney: What were the biggest constraints to implementing that program? Or to first getting acceptance by The Surgeon General?

BG Dunlap: Shortly after I had been there, and thanks to the relationship I had with a number of the MSC [Medical Service Corps] officers who had been my students when I was teaching in hospital administration and were now in some key roles in The Surgeon General's Office, I received some advice about working with the staff in The Surgeon General's Office. I requested that I provide a briefing to The Surgeon General and his staff about the ANCP program. This was the first briefing I gave to the staff. I had not been involved in all of the details prior to that, but Sue Frazier had. I gave the initial part of the briefing. That included my concept, my concerns, and so forth. Sue gave the detailed briefing. Well, we had an impact. It was accepted. I was told that was the first time that The Surgeon General had been briefed on what nursing was trying to do. There had been work done with [Colonel] Tom Whelan and [Colonel] Marshall McCabe, who were in the professional side of the house. But there had been no work with the total Surgeon General's staff. Once it was accepted and the rest of The Surgeon General's staff knew that this was an approved program and we would be working together on the development and presentation of it, then getting to the other members of The Surgeon General's staff to include budget, training, and professional, and all, was easier.

I can never overemphasize the work done to develop the sites and the curricula by the group of nurses who were there in the office at the time. I think it is recorded in our history that in January 1972, the first students entered the Army Nurse Corps Clinician Program to prepare as nurse clinicians in ambulatory care, OB/GYN, and pediatric nursing. They graduated in June of '72. From September of '71 until January the program was developed and then the first group graduated in June of '72. That was quite an introduction to being Chief of the Army Nurse Corps.

Oh, that group was tremendous. We sent Jean Barcus, who had been in on the development phase, down to Fort Benning to be the course director of the ambulatory nursing care course. It needed that type of strength to get these programs going and to work with a young faculty. We also had a chief nurse down there at Fort Benning, Lieutenant Colonel Sally Stallard, who had been a student of mine in the career course. She had been chief nurse at Fort Meade when I was chief nurse at First Army and had been my medical supervisor when I was chief nurse in Okinawa. She was chief nurse down there when Colonel Zipperman was the commanding officer there. Sally had such a beautiful relationship as chief nurse with the professional and administrative staff. We needed that if we were to have the ability to set up the program in that setting.

There were problems. Any time you're defining a role, there is. But at least they were able to define it. I was invited then to go down to give the graduation address for the first class to graduate in June of '72. I've got a whole album of that trip down there. But this shows you how a group was able to do what they did by winning the support of the hospital, despite the fact that they were kind of a sore

thumb being the new group coming in. They placed certain additional requirements on the staff but they were able to work with the hospital and the post.

When I went down to give the graduation address and to cut the ribbon at a new clinic facility that they were opening up there, I flew into Atlanta. They sent a fixed-wing plane up to Atlanta. So, I got off a great big Delta jet to get on a little tiny puddle jumper. They wanted to fly me into Benning so I could land on the strip, right out on the parade ground. They had the Honor Guard out there and the red carpet. I've got pictures of all this. I was met by the hospital commander and escorted through the Honor Guard. Then, of course, I paid my courtesy call on the post commander. We participated in the ceremonies, the graduation and all. I was with him to help cut the ribbon. Then, that night, they had a big formal affair. That was all a result of the relationship that had been developed between January and June of that year.

But, as we all know, Army Nurses can get things done. (Laughter)

Attitudes of the Physicians

MAJ Gurney: What were the attitudes of the physicians toward the program?

BG Dunlap: It varied. At the same time, the physicians in the Professional Activities Office were developing the Physician Assistant Program. So, the physicians had already recognized that they needed help.

Some of them had worked with nurses in the past who had really unofficially expanded their roles in many settings. The physicians knew that we could do it. They, and we, were all at fault some, I think. Some of our nurses, and the nursing profession, were talking about taking over physicians' posts. Well, that isn't the way I looked at it. I looked at the expanded role of the nurse as not really decreasing the role of the physician. Some said we were going to substitute for the physician and become little physicians. In our nursing profession I think this controversy still exists sometimes. Some of the civilian nurses then went into the physician assistant programs that they had in the civilian community. They became physician assistants rather than keeping their identifiable role as an RN.

These things were thrown back and forth. Many of the physicians welcomed the nurses working in the nurse clinician role. Just think in terms of ambulatory care particularly, and the mobs of patients in ambulatory care. As I look back on it, those retirees with chronic problems go into the ambulatory care setting in our clinics. How many of us need to see the physician every time we go in? The physician has to make rounds on the wards. They have to attend the professional staff conferences and cover in the surgical area. They hold the surgical clinics and do surgery and all of that. Where we have nurse clinicians working in those settings, many of our patients want to go to the nurse clinician. They provide a certain continuity there. I'm thinking of one here at BAMC who's been here a long time. This is one nurse clinician, I tell you, the retirees want to go to all the time because they feel very confident that if there's anything that she questions, she goes to the physician. She has the expertise and the knowledge to manage and direct their care. Well, that was the concept we wanted. The physicians who wanted to work

with us certainly accepted it. Our nurses made a tremendous contribution in ambulatory care.

MAJ Gurney: Were there particular strategies that you used to win the physicians? Was it a matter of simply communicating the role to them? Or examples of the role? Or people relationships?

BG Dunlap: We came up with parameters of practice when developing the nurse clinician program. We got into a controversy about writing prescriptions and ordering medication. This had to be something that was developed at The Surgeon General's level. Then it had to be worked out at each hospital level because we didn't have, at that time, the quality assurance and the credentialing emphasis that you have now. This was a forerunner of that because if nurses and later physician assistants were going to be allowed to do certain things, they were going to have to be credentialed. This was followed then by using these other health care providers. I'm trying to think of the terminology. They wanted to use physician assistants for the doctors or the nurses. I insisted on the expanded role of the nurse, not . . .

MAJ Gurney: Physician extenders?

BG Dunlap: Physician extenders. Every time a document came through with the terminology "physician extender," I crossed it out and put in "health care providers." I did not see it as extending the role of the physician but rather expanding the role of the health care provider, the nurses, the AMSCs and so forth. Those things become accepted by developing guidelines and then developing the individuals who are working within those guidelines.

Medical-Surgical Nurse Clinician

We had problems at different facilities at different times depending on the people. But I think our ambulatory care nurse clinician was probably the first program accepted. That was based on the large number of patients we had to take care of. Now, you get into med-surg area, that's another situation.

MAJ Gurney: Still related to the ANCP?

BG Dunlap: Yes. Implementation of the med-surg nurse clinician. We asked the question, "Do you want to just keep her in ambulatory care? Is she going to be able to work in the medical specialty clinics where she is working with the diabetics?" She may be working with the cardiac patient, hypertensive, the arthritic patient, and the different medical specialties. We felt that there had been demonstrated need for them to work in those specialty clinic areas. That wasn't as readily accepted as the total ambulatory care area, although the ambulatory care program was primarily med-surg. But we felt that they should be able to work in these other clinics, particularly like the diabetic, arthritis, and hypertension clinics. This had

them working in those three areas of chronic problems to manage those patients. Some places agreed to do it, other places did not. It depended on the physicians that the nurses worked with.

Pediatric Nurse Clinician

MAJ Gurney: Pediatrics?

BG Dunlap: That's interesting. Pediatricians and pediatric nurses are so much alike. (Laughter)

Doesn't the Bible say, "The children will lead us"? Maybe their patients led them to work closer together. For the pediatric nurse clinicians, I think this role was identified and implemented with perhaps fewer difficulties. Some of them may not agree with me. But at least I think so.

Obstetrics/Gynecology Nurse Clinician

Then we get into OB/GYN. Is the OB/GYN nurse clinician just going to do pap smears? Will they just weigh patients and do pap smear? Because even just that is tremendous. There is an emphasis on pap smears, you know. I think some thought the OB/GYN nurse clinicians just do pap smears. That would take a big burden off the physicians if they did that. Well, that was not the purpose of the OB/GYN nurse clinician.

Nurse Midwifery Program

Then we get into the nurse midwifery program. That's the one of course I'm so proud of. The nurse midwifery program was developed at the master's level. The University of Kentucky is the school that had a master's program in nurse midwifery. We worked with [Lieutenant Colonel] Celeste Lillard. I was trying to think of her name once before when we were together talking about nurse midwifery.

She and Mary Mulqueen were the two certified nurse midwives that we had. They developed a program at Fort Knox working with the University of Kentucky. The students received the didactic from the University of Kentucky, their clinical at Fort Knox, and earned a master's. Fort Knox was an ideal place to develop the nurse midwifery program. It had large numbers of deliveries there. Also, Kentucky was accustomed to nurse midwifery practice since they had the fine program at the University of Kentucky. Just a little sideline—Dean McKenna at the University of Kentucky was the mobilization designee for the Chief of the Air Force Nurse Corps. She was so concerned because the Air Force Nurse Corps would not develop their programs like we were doing it. She was so delighted that the Army was doing it. She said, "Every time I go in for my mobilization designee duty I talk about it. But it's the Army that's doing it."

The philosophy behind the development of the nurse midwifery program, and I think the practice of nurse midwifery, is that the nurse midwife would work with the patients through the prenatal part of their care. Those patients identified as potentially having normal deliveries, the nurse midwife delivered them. Those with

problems during their prenatal care transferred to the care of the physician. It was never the intent of the nurse midwife to take care of all types of OB patients. The obstetricians accepted this in varying degrees. At Knox, because of the tremendous leadership and professional skills of the two nurse midwives we had there, it soon became apparent that it was easier to define this role. Having it at a higher educational level enabled all of our graduates to have the master's degree.

Barbara Schrader, wasn't that her name? She was a nurse midwife. She had worked as a nurse midwife, but she did not have her degree. We sent her to the University of Kentucky to have the formal preparation. That program then was to be expanded. Where do you expand it? Well, to the post hospitals, not the medical center, but to the post where you have the most deliveries. The post has all those young troops all taking a lot of Vitamin E, I think, or something, and all the deliveries. Fewer obstetricians were being assigned there. So, where would we expand? Well, Fort Campbell was identified and Fort Hood.

Fort Campbell was in Kentucky. It straddles Kentucky and Tennessee, but Kentucky was a state that had already accepted nurse midwives. Texas did not. I wasn't so sure about coming to Hood. How would this be accepted? But the practice is on federal property. So it could be done on federal property in federal facilities. Those were our two expansion efforts. I don't know where they are now. Europe, I know, wanted them. I don't know about the nurse midwifery program today.

MAJ Gurney: Did they go down to Fort Bragg too?

BG Dunlap: That was not in the planning. First, they would be at Campbell and next they would be at Hood. Dr. [Colonel] Warren Patow was the chief of OB/GYN at Walter Reed and was the OB/GYN consultant for The Surgeon General. Of course we worked closely with him in identifying where they would be assigning the obstetricians. We were working with them to plan the distribution of obstetricians as we were planning for these two hospitals before we expanded the nurse midwifery program.

University Affiliation

Along with that program we wanted to follow through on the philosophy of our nurse clinician program being affiliated with the university. This came at a later date. Colonel Margaret Ewen, who was director of the Nursing Science Division here at the Academy of Health Sciences, was the one who did this. We wanted to affiliate our nurse clinician program with some university. The graduates of our programs would receive some credit toward their master's degree. Searching out the universities where this could be done was not easy because each had its own requirements, (Laughter) as you well know. Colonel Ewen was able to work with the University of Texas Health Science Center, here in San Antonio, and with Colonel Neil McDonald, MSC, who had been in The Surgeon General's Office. He was down here at the academy at that time as the dean. He certainly supported us. He'd been a student of mine in hospital administration too.

He supported us and helped us along the way so that this affiliation could be established. But when you're establishing an affiliation with the university, the university has requirements to assure the quality of education. They did not want to grant credits for any program that would only be under the supervision of the military. They must have their assurance also. It had implications for the budget then, because this means that they're going to have to make a staff visit to review the curriculum. They would have to be involved in the whole process, review the curriculum and the credentials of the faculty members because they did receive faculty appointments. Then they would make visits to the sites. For the Nurse Midwifery Program, students would do their didactic phase at the University of Kentucky and Phase 2 was at Fort Knox. They received their master's degree from the University of Kentucky. This university affiliation meant that we'd have to develop the budget for travel. You know, in any Army program, one of the first things that's cut out is travel. But Colonel Ewen was able to get that set up at the academy. This was in October of '74. For the first time, the Army Nurse Corps officer could receive graduate-level credits for any one of the five nurse clinician courses (other than midwifery) through the University of Texas School of Nursing here in San Antonio. The midwifery credit came out of the University of Kentucky.

For the record, the nurse clinician ambulatory care course was given at Hayes Army Hospital at Fort Ord [California] and Martin Army Hospital at Fort Benning, Georgia. The nurse clinician intensive care course was here at Brooke and at Fitzsimons. The pediatric nurse clinician course was at Fitzsimons and Madigan. The OB/GYN nursing course was located at Fort Bragg, and the psychiatric mental health course was at Walter Reed. Our nurses attending these nurse clinician courses received 16 semester hours' graduate credit.

While this was going on, for our Army health nurses we worked up a program with the academy. It pertained not just to the Army health nurses but to the other members of the preventive health team. They received graduate credit from Tulane University as a result of the courses that they were taking.

The emphasis was that our specialty programs were postgraduate nursing programs. Students received graduate credit upon completion of those courses. Eventually, they'd be able to continue on and use those credits toward their master's degrees.

MAJ Gurney: Along this line, what is your feeling related to the movement in the ANC to phase out these courses in favor of the master's degree clinician prepared in civilian institutions of higher education?

BG Dunlap: I'm always very careful in my comments about differences between the past and the present because I realize there are different situations and different requirements being placed on the Corps. Our program required a large number of instructors prepared at the master's level. The nurse clinician or practitioner programs, as you call it now, in civilian universities are better now than they were at that time. They were just beginning in the civilian sector, too. Preparation

in the civilian university as opposed to the military has advantages and disadvantages. One of the disadvantages is that we would then not have the programs in our own hospitals and institutions. In the Phase 2 part of the programs, students were working in the military setting and working with the military people they'd be working with when they became a practitioner. If they go to a civilian university, they're not doing their clinical experience in a military environment. So they were bringing the theory in just as they received the theory in our program, but the practice then had to be developed in a military setting.

MAJ Gurney: Is that setting so different from the civilian setting?

BG Dunlap: It's different. Our civilian hospitals are different from military hospitals. The people they're working with in the military hospitals while they were in Phase 2 of the program were the people they were going to be working with throughout the rest of their career possibly.

BG Dunlap: If they're doing their clinical master's in a civilian hospital with a civilian group and they graduate from that program, then they go into a military hospital to start practicing. They're moving in with an entirely different group, a hospital they may never have been assigned to before. But it's an entirely different group to begin their practice with. Unlike the civilian program, in the military there is always someone at a hospital that you go to that you've worked with before, someone you've known before.

This same question came up back when we started, when we were sending Army Nurses to the Hospital Administration Program. Do you prepare our future chief nurses by sending them to civilian colleges to get their degrees in nursing administration? Or do you send them to the Army-Baylor Health Care Administration Program? I am grateful that the people there at the time the decision was made that I could go said that I could go to the Army-Baylor Hospital Administration Program because I did my residency in an Army hospital and I really learned about how an Army hospital operates. The people who were classmates of mine in the residency program were people I worked with throughout the rest of my career. We became senior officers in the decisive positions. We already had that rapport and appreciation and respect for each other's abilities. We didn't have to establish that. To me, that's one of the advantages.

But then I prefaced my statement by saying I hesitate to compare past and present, because this is a different situation today for the Army Nurse Corps than at the time our Nurse Clinician Program was being established. I think it has to be the judgment of the people making the decision today as to what's best for the Corps for today.

Career Progression for the Nurse Clinician

MAJ Gurney: I have another question related to the ANCP. What did you imagine would be the career progression for nurse clinicians following their graduation?

BG Dunlap: Practice. I pictured these nurses as beginning practitioners in their field learning to put into practice what they learned. I considered them in particular at a troop post, not so much in the medical centers, but in our posts where we had a great number of patients being seen. I felt this practitioner could be more independent and progress in her practice better at a post as opposed to the medical centers, until she really had gained a good deal of experience. In the medical centers, they're competing with the residents and the interns and they're the low man on the totem pole as the new person coming into a newly defined role. I felt that a fuller utilization and better learning experience would be available at the post or troop units.

MAJ Gurney: Could that person then become a senior captain, major, lieutenant colonel, and remain and work as an expert clinician in that role?

BG Dunlap: Well, then you get into the rank business. And you know, we have only certain colonel positions and lieutenant colonel positions. It's just like any MOS at that time, when they became full colonels; they either had to be the chief of the Operating Room or the chief of the Nursing Service or such services. We didn't have full colonels in assistant chief positions at that time. They would have to move out if they were full colonels, particularly at a post, because the chief of the Medical Service might be a lieutenant colonel, and we didn't have that many colonels in nursing anyway.

MAJ Gurney: Did you feel, though, that even if they became majors and lieutenant colonels they could have the second, third, or fourth tour as a nurse clinician?

BG Dunlap: As they developed in their field and then move on to the medical centers when they would be professionally competent, their level of expertise could be used in the medical centers, but I really saw them at the post. We had big hospitals. We think of them as small hospitals, but if you look at the civilian community, our little hospitals are big hospitals with big responsibilities.

Would the nurse clinicians eventually become chief of Nursing Service or, that old question, do they have to move out of their clinical area? I think with the rank system, our full colonels, most of them, have to move out of the clinical area. As we get more full colonels they haven't had to move out of the clinical area as much, but at that time they would certainly have to move out of the clinical area.

Well, wouldn't he or she be a much better chief nurse with that experience?

MAJ Gurney: Wouldn't he or she be an excellent clinician with those many years of experience and teaching in the ambulatory care clinician role?

BG Dunlap: That's right. Teaching in, or heading up, the program to prepare our nurse clinicians is a very important role for those senior practitioners.

MAJ Gurney: It was very difficult, and you left your role as Chief of the Corps probably before we began to feel the first ramifications of this, but it was very dif-

ficult for them to get their second or third tour as a nurse practitioner or nurse clinician.

BG Dunlap: Because of the rank structure?

MAJ Gurney: Because of the need to give them the variety of experiences needed to make them competitive for promotion. This was something that we experienced later on.

BG Dunlap: How was it resolved?

MAJ Gurney: I don't believe it's been totally resolved, and a lot of unhappy people were forced out of the role in order to be competitive.

BG Dunlap: But isn't that what's been going on in the nursing profession?

MAJ Gurney: That's true. And it's true throughout the entire clinical structure, not necessarily unique to the nurse clinician. The officer can spend only so much time in a staff role or as a staff nurse on a unit, but they eventually have to move into other areas to broaden their experience base and make themselves competitive for retention and promotion.

BG Dunlap: Look at the positions. To be a commanding officer, physicians have to move out of the clinical area. As they become chief of the Department of Medicine, they're still clinical, and then as they become a commanding officer, they're out of the clinical area. Or, in the case of the deputy commander, he is chief of Professional Services so he's still clinically related, but he's not in clinical practice. But that's the rank structure. It's the Army structure. If you look at the Signal Corps—do we still have a Signal Corps in the Army? Are any of them [senior officers] where they have the technical expertise? Consider the rest of the Army, whether senior officers are from the computer field, or electronics, or any career field, when they become a general officer or a top person in that particular field, they have to move into the top positions of administration or staff. So, I don't think it is unique.

MAJ Gurney: No, it isn't.

BG Dunlap: It isn't unique to us in the Army or to Army Nurses as opposed to civilian nurses. I can remember throughout the years, how we talked about developing nursing services in our civilian hospitals and in the military. We had to justify, first, lieutenant colonel spaces and then colonel spaces, to have the chief—what do you call them now in the operating room? What is it?

MAJ Gurney: Chief of the Operating Room or chief of Perioperative Services probably.

BG Dunlap: Something like that. We had to justify that as a full colonel position if we wanted to have more colonels. Where are you going to justify those positions? They would be the chiefs of the different sections. We justify those slots so they could progress and stay in the operating room, but then when you come to the Chief of the Army Nurse Corps or the, assistant chief of the Army Nurse Corps, that's going to be someone who's not in her clinical field. What preparation has she had to be Chief of the whole Corps if she stayed in the operating room the whole time? I am not just picking on the operating room, but that's an area that is more isolated from the total hospital operation.

How about an Army health nurse who has stayed within that field and has become the full colonel and head of that community health nursing section at a medical center? She's had more staff experience than an operating room nurse or a nurse anesthetist. Could she be Chief of the Corps in the present-day environment where the emphasis is on Command and General Staff College?

MAJ Gurney: And broad-based experience.

BG Dunlap: Yes, broad-based experience.

So, what are the goals of the individual? I don't think we'll ever solve that, but that's not our problem.

MAJ Gurney: They will find their track to meet their goals.

RELATIONSHIP WITH THE PROFESSIONAL ORGANIZATIONS

MAJ Gurney: What were the opinions of the professional organizations regarding what you were doing with the ANCP?

BG Dunlap: Total support.

MAJ Gurney: Really?

BG Dunlap: Oh, I'm real bold in saying "all" and "total" like that because there's always someone who doesn't support you. Our professional organizations, I think, have always looked on the Army Nurse Corps as being a leader in the nursing profession, whether it was in practice or education or research. We had very good relationships with our professional organizations.

You're going to ask me who was president of the ANA at the time and I'm trying to think of whom it was.

MAJ Gurney: We don't have to worry too much about that. But how did you develop those relationships? How did you get their support?

BG Dunlap: We developed relationships with the ANA and the NLN by ANC participation in the professional organizations. When I was at MFSS I served on the

national committee for the NLN in the development of the criteria for evaluating nursing services administration. This was a result of who was the director of the NLN. The executive director was a former Chief of the Army Nurse Corps, Inez Haynes. She had seen to it that I was recommended. I was appointed, and I became very active in the NLN. This has happened throughout Army Nurse Corps history—I hope it continues—that the nurses at the stations or their hospitals are active in the local districts, ANA and the NLN, and that they stayed in at the national level. I certainly think when [Brigadier] General [Hazel W.] Johnson-Brown retired and went to work at the ANA, just like Colonel Haynes had done when she went to NLN, that shows the relationship between the Army Nurse Corps and the professional organizations. But it can't be just the Chiefs; it has to be at all levels of both organizations. The ANA has supported the Army Nurse Corps in war and peace.

Graduates of NLN Accredited Programs

I will give you an example. In The Surgeon General's Office, one issue, which we still face today, is NLN accreditation. This specifies that we accept graduates of only NLN-accredited programs. During my time there, some, including some at DoD level and in the Office of the Assistant Secretary of Defense for Health Affairs, felt that we should take into the Army Nurse Corps as commissioned officers anyone who had an RN regardless of the educational preparation. We, in nursing, did not believe that, and we thought that they must be graduates of an NLN-accredited program. I could talk myself blue in the face and any other Army Nurse, too. How was I going to try to get this across to The Surgeon General, who was responsible for policy?

I invited Dorothy McMillan from NLN to come to The Surgeon General's Office to speak and to meet with The Surgeon General and discuss NLN accreditation. She did. I had met her when I served on the committee at NLN. I felt that if NLN came down and explained what the accreditation process is, The Surgeon General and the professional staff would have more of an appreciation of what we were trying to do. It worked.

MAJ Gurney: Do you happen to know when that meeting with Dorothy McMillan was?

Supporting the WRAIN Program

BG Dunlap: I don't recall. Another example of professional relationships was when the pressure was being put on a certain general to discontinue the WRAIN program. I needed help from the professional organizations on this issue related to nursing education and why the WRAIN program should be continued. We cannot legally lobby Congress.

I contacted Jo Elliott. This is something that we will have to use discretion with. Jo Eleanor Elliott had been president of the ANA for two terms, which was unusual. She was now the executive director of the Colorado Nurses Association. Jo Elliott has always been a supporter of the Army Nurse Corps. Her very good friend, Colonel Erin Cannon, was one of our chief nurses. I talked with Jo about

this because of my concern about WRAIN. I also talked with the dean of the University of Maryland, Dean Marion Murphy, Ph.D. They were both concerned about the WRAIN program being discontinued.

A notice came to The Surgeon General's Office in December for us to testify on the WRAIN program because the budget was going to be considered in January. The testimony would need to be prepared at DoD to be sent forward to Congress. They wanted to eliminate the WRAIN program.

MAJ Gurney: What year was that? December of —

BG Dunlap: Governor William Clements in Texas was the Assistant Secretary of Defense. James Schlesinger was the Secretary of Defense. Probably December of '74, I think it was. It was shortly before I left. Governor Clements signed the paper. I want you to know that the civilian nurse educators and leaders rallied around the Army Nurse Corps. Esther Lucille Brown, all of the deans of our universities, and nursing leaders began to write, call, telegraph the Secretary of Defense and The Surgeon General in support of the WRAIN program.

Well, when all of this response came in at the DoD level, The Surgeon General called me in and never questioned if I had had any part in it or not. But over at DoD level he was advised of what was coming in. They wanted information papers prepared to respond. You know how you have to do that. Eventually, if it's nursing, it gets down to the Chief of the Army Nurse Corps to prepare the response.

This gave me an opportunity to prepare a response that The Surgeon General, who we had convinced to support us, would present to the Secretary of Defense back across the river. I can remember so vividly. As you know, these papers come down, budget and everything else, in December when everybody, including Congress, is going home for Christmas vacation. Everybody else is going on Christmas time, but we had to have our response prepared by the time they got back in January. Secretary Clements delayed a decision because of all of the letters and calls that had come in. Ultimately, when the budget went forward for that year, we still had the WRAIN program.

We weren't so fortunate in years to come. But that was an example of how our professional organizations supported the Chief of the Army Nurse Corps. The Chief of the Army Nurse Corps always felt that the president and the leaders in the professional organizations were consultants. They might not have been appointed consultants; they were still consultants. We had our Federal Nursing Chiefs, Federal Nursing Council, which was comprised of the chiefs or directors of the five federal nursing services. They worked closely with the professional organizations and all took leadership roles in the professional organizations.

THE PHYSICIAN ASSISTANT PROGRAM

BG Dunlap: Maybe I could address another one of those issues facing me as I enter the Office of the Chief. This was the Physician Assistant Program. It parallels the concept of the Army Nurse Clinician Program.

BG Dunlap: The concept had come out of a meeting that General Hays held with Army Nurse and civilian consultants. As a result, they designed the ANCPP [Army Nurse Corps Contemporary Practice Program]. At the same time, in the Medical Corps they were developing the Physician Assistant Program. I had a number of senior nurses and some not so senior say, "I'll never take orders from a physician assistant." They pictured the physician assistants giving them orders, supervising nurses. That was not the position that I took. My position was that there's plenty of work for everybody as long as we in nursing define nursing's role and how our nurse clinicians will function. Likewise, the physician assistants' roles would be defined and how they will function. I wanted to go ahead and try it.

Let's face it, there were some nurses who were doing physicians' work. I can give you example after example where I and many other nurses did things that physicians were supposed to be doing. But they were in the operating room or they were busy, and they couldn't do it. We were running the ward. We wanted to be sure that the patients got taken care of without waiting for the physician to come at 10 o'clock at night to do some of those things. The physician had confidence in us and he'd say, "Go ahead and do it," and we did. Now, maybe that's good, maybe that's bad. I don't know. Legally, I don't know. But we never had any trouble or any adverse effect. I think based on my experience that I felt that there was an expanded role for nursing, but we must have our role defined. And we must practice within those limits.

MAJ Gurney: Do you feel that we succeeded in that?

BG Dunlap: I think we did. If you look at the program today, it's gone even beyond that. It depended on your commander. It depended on personnel. When they let the nurse clinicians practice as they were prepared to practice, it was a great success.

I also always think of our nurse midwifery program because I'm proud of that. That was something that came about during my administration. The school was at Fort Knox. We had tremendous OB nurses. Lieutenant Colonel Mary Mulqueen was a nurse midwife working with the University of Kentucky. They set up the program at the master's level and had a commander and chief of OB out at Fort Knox who supported nurse midwife practice. That is why the program was so successful. They expanded it. I think Fort Hood took midwives, and then they got into the overseas area. Fort Campbell also had them. I don't know if they still have them now though.

MAJ Gurney: Yes, they're still at Fort Campbell. They're also still at Fort Hood and Fort Knox, and they're trying to get into Fort Bragg and a couple of other places. I was just down at Fort Knox two weeks ago and we were discussing this.

BG Dunlap: But the important thing was that in setting up that program, we agreed that the nurse midwife would fulfill certain responsibilities and she wouldn't attempt to manage the complicated cases. The obstetrician is the one who

should be doing that. It was because of personnel who respected what their capabilities and limitations were that the program was successful. If the nurses had tried to be little doctors, it wouldn't have been successful. The physicians gained a great deal of respect for the nurses. It got to the point where the patients preferred to have the nurse midwives take care of them.

The Physician Assistant Program was developed in the office of the Professional Services chief, Colonel Tom Whelan, and Colonel Marshall McCabe. It was being done independently, and the nurses were developing the ANCP independently. The nurses were resisting the Physician Assistant Program. I had heard some senior nurses say, "I will never take any orders from a physician assistant." I'd say, "Oh, are you going to have to?" The programs were being developed, and they could see the physician assistant giving them orders, nurses coming under the physician assistant. They pictured them doing the things that the physician did including writing orders and directing nursing as the physicians were doing.

There was some undercurrent because it was felt that the two programs were contradictory to each other. Well, I have found in my experience that the most progress I have been able to make is when I have been able to—not reconcile—but try to negotiate and work out agreements between two opposing programs, elements, or individuals, and not saying, "That's right; this is wrong. We won't do that."

I don't want to imply that I give in easy, because I don't. But I felt—as a matter of fact, I'd say, "Let the physicians have their assistants. They are comparable to our practical nurses." We needed assistants in nursing, so we developed the practical nurse. Then we needed still more assistance and we developed nursing assistants.

The nursing profession and we, as nurses, are saying we are no longer their handmaidens. Let them develop their own assistants. Since they're thinking in terms of mostly men, they'll find that it isn't a bed of roses. Soon those men are going to want to be doctors, and they're going to want to take more and more of the doctor's role. Some doctors are going to be willing to give it to them and others aren't. So, they're going to have their own problems in developing the role of a physician assistant.

That's where I got into insisting on the terminology of "health care providers" because I felt that the AMSCs and the PTs [physical therapists], who were developing a program for the PTs, were also expanding their roles. We were all redefining the roles of health care providers and we should work together in redefining these roles. I felt that we and The Surgeon General's Office should be working with the professional consultants group in defining the roles and the utilization of both kinds of practitioners. Truly, the patients needed so much care, and we needed more people to do it. We knew we couldn't have doctors and we couldn't have RNs doing all this care, and we needed people prepared to provide different levels of care.

So, my approach to the Physician Assistant Program was not one of opposition, or that we were going to compete with it with the ANCP. An agreement

was reached for developing the Physician Assistant Program that the physician assistant would be assigned out in field units where they needed them. In the field units they would not be in competition with the nurse clinician. That's where they were being utilized first in the program. I know it has changed, as they have wanted to get them into the different clinics and the medical centers. When I was a patient at Brooke I had physician assistants taking care of me with the physician.

During my time, this was my approach to the development of the Physician Assistant Program. There is so much to do that the physician assistants, utilized in the battalions where there is a need down there for them, is not in conflict with the Nurse Clinician Program. So, let's go with it. I can support your Physician Assistant Program if you can support my Nurse Clinician Program.

MAJ Gurney: Did you have input into the definition of their role?

BG Dunlap: The step-by-step of their role? No, they were going to be in the battalions. They weren't doing nursing.

MAJ Gurney: Yes, but I wondered if you had input into the role as the physicians developed the concept and defined what that role would be.

BG Dunlap: It was staffed. These things were staffed. That was in the early part of my tour there as Chief. As we get later on in my tour, as Chief of the Corps and personnel changed in The Surgeon General's Office, the staffing of some personnel actions and staffing in general, did not always go through the Corps Chiefs. But our Deputy Surgeon General, Robert Green, would call me and say, "Lil, have you seen this?" if he didn't see my mark on something that went to him. If I had not seen it, he would insist that I saw it. He insisted I saw anything that pertained to nursing or that would impact on nursing. I was fortunate that I had a Deputy Surgeon General who did that. It had not always been done in The Surgeon General's Office. There were a number of actions that got to him that had an impact on nursing service, not necessarily the Army Nurse Corps but nursing service, which had not been staffed through me. He would not act on it until he saw my mark on it or he had talked with me.

Now, in the case of the Physician Assistant Program, certainly things like this were staffed. My approach to this was that PAs were not working in a nursing situation. They were not doing nursing. They were under the supervision of a physician for extended physician roles. As a nurse, I might have concerns and I could express some of them, but that's not my responsibility; my responsibility was as a staff officer to respond to any staff paper with my opinions and recommendations. Just like I wouldn't want any doctor to tell me how to run nursing.

UNIFORMS

MAJ Gurney: Were there other issues you faced just as you entered the role?

The Importance of the Uniform

BG Dunlap: Every chief nurse has faced uniforms, and will always face uniforms, as an issue. We had all been involved, at different times in our careers, in uniform changes and we'd have to change with every uniform. We said, "Who on Earth decided up there that we would wear this?" The prime example was the Hattie Carnegie uniform in the '50s. It was that taupe thing that we called the "nursing mother uniform" because it had those fake pockets. Anyone with a bosom made those pockets expand and you can see how it got its name. Many of us would stitch them down. We called that the "nursing mother uniform."

MAJ Gurney: Oh, dear. (Laughter)

BG Dunlap: I've been involved in having to change uniforms all those many years, and we don't get any uniform allowance to buy the new uniforms. I've been in key assignments where I was before the public all the time, even as a captain on recruiting. I had to have all the uniforms and look spit-and-polish all the time. The subject of uniforms exhausted me then, and continues to exhaust me as I think about it.

For example, the uniform you have on right now, I don't know you're a nurse. That was one thing, in changing our uniforms; we lost the ability to tell a person's branch. We always wore our insignia in the AMEDD. General officers in the AMEDD, as an exception to general officer policy, the chaplains, the AMEDD, and I think the JAGs are exempted and are allowed to wear their branch insignia.

When the Air Force was organized, they tried to be as different from the Army as they could so that they would be an identifiable service. You can't blame them. So, a lot of the things that we did in the Army they didn't do, organizational and otherwise. Their uniforms were like the one you're wearing now, in that they had no identification of the individual's Corps. We just thought that was terrible. How are you going to tell an Air Force Nurse? You couldn't. Then those who had flight nursing wore the wings. You knew that was a flight nurse. But you couldn't tell the others.

We weren't faced with that during my time, other than thinking that we didn't want to change. We wanted to keep the uniform we had. At that time there was still a WAC Corps and we had many of the enlisted WACs working in medical facilities. Naturally, as chief nurse of a hospital and Chief of the Corps, I was concerned about the uniform that they wore in the medical environment. I also had some strong feelings about what the officers wore too. I still do. The Director of the WACs and I as Chief of the Army Nurse Corps, both general officers, were on the women's uniform board.

If I can digress just a minute—The Chief of the AMSCs was not a general officer and wasn't on the uniform board. So, anytime I was on anything that was general officer only, I coordinated with the Chief of the AMSCs to see what her position was so I could represent her position, even with The Surgeon General's Office or any other function. I told The Surgeon General that I felt that the Chief

of the AMSC should be included in all chiefs' meetings or sitting on all boards even if she wasn't a general officer. Also, when they had a commanders' conference in The Surgeon General's Office and the medical centers, they were all general officers. The CONARC Surgeon was a colonel, not a general, and he wasn't included in some of those, because it was just general officers.

General Kerwin, DCSPER, headed the uniform board. I just loved that man. I had him come speak to a chief nurses' conference one time on personnel issues. He was tremendous. The chief nurses loved him too. They wanted him to come again.

It was a delight to serve on one of his boards because he was all business. We got things done, but yet he had that sense of humor. When they brought up all those campaign hats and things like that, for the men to wear, he'd model them. (Laughter)

BG Dunlap: I was laying the groundwork to talk about Colonel Inez Bailey, Director of the WAC. Because of her position and because of mine, we both served on the uniform board. We were two entirely different people. We represented two entirely different groups, although I had an interest in the portion of her enlisted personnel who were assigned to nursing service. Her branch had different problems than mine.

The WACs needed to have a uniform that would be more glamorous.

MAJ Gurney: Why?

BG Dunlap: For recruiting purposes. The blue uniform of the Air Force was much more attractive. The blue will always be more attractive than our green. I wear blue in civilian life. But if you looked at the uniforms side by side, the blue, just the color of it, was much more attractive.

Beret Cap

As Director of the WAF [Women's Air Force], Jeanne Holm had been very progressive in designing uniforms for women in the Air Force. This is what General Bailey faced. She, herself, was a fashion plate and very fashion-conscious, whereas, in the Army Nurse Corps, we certainly want to be fashionable, but we want to have a certain professional look about us, too. I, being an old stick-in-the-mud, didn't approve of that beret. I thought it was terrible. I wanted that visor hat. During my term, we had visor hats. We had the beret, but I felt that in formation, when the men were wearing the visor hat, we women should have our visor hat and not that beret. That's before the men were wearing the overseas caps that much, and the overseas caps were not authorized then for women. The Army was going away from those and we were to wear the beret.

I saw that beret, and I want to show you someday the pictures of the bunch of nurses I had in The Surgeon General's Office pulling hanky-panky on me. We were going to test the berets, so they sent us test berets. All these officers came up to my office to get their beret. People like Sue Frazier, Kitty Betz, Marian Davis,

and others put on those berets in all kinds of different fashions to tease me about it. I still do not like the beret. I do not like to see our women wear it because it is plopped every which way you can think of, and to me, no way is complimentary to the rest of the uniform.

General Bailey loved the beret. She didn't like the visor hat because she had a bouffant hairstyle and the visor hat pushed it down. We used to tease her; we thought that she slept in the beret. I can probably count the number of times I wore that beret on one hand because I just did not approve of it. But then, when you have two people on the uniform board representing two different views, you can't have women fighting women. That's what the men love. So, I would have to give a little on some optional type thing.

"Jolly Green Giant" Uniform

Our women were wearing the green-and-white-striped cords. They were cool, they were comfortable, but they were sure messy. They got so wrinkled. They really looked like a duty uniform. We wanted to come up with a new uniform to replace the green-and-white cords. That's when we came up with the "jolly green giant uniform." The effort was made to make a uniform kind of like civilian clothes. Women would have a mix and match wardrobe so that for different occasions and different places they serve, they can mix and match the jolly green giant uniform.

MAJ Gurney: Really, what we're talking about here is the mint green uniform? (Laughter)

BG Dunlap: Mint green. There were different shades of green debated for the uniform and different styles. There would be one piece that could be worn as a one-piece dress. It could have a jacket with it too to dress it up a little bit. They had a skirt and different kinds of blouses, long-sleeved, short-sleeved, open collar, or collar with ties. There was a one-piece vest that could go with it.

The purpose was to develop a uniform other than Class A's that could be worn at all different times. There has to be a better way to develop a uniform than through Natick [U.S. Army Natick Soldier Center]. It takes so long to develop the uniform, test it, have it manufactured and distributed. Women make up 10 or 12 percent of the Army, or something like that.

MAJ Gurney: I think it may be even more than that.

BG Dunlap: I don't know. But at that time we were such a small percentage of the total Army. When developing a uniform, they think in terms of the large numbers that they are going to have to develop for. Instead, with the women, there have to be so many different sizes. Particularly they get into shoes and boots when you're developing things like that. You have the AAAs and AAAAs. Plus for women you have the short and the medium and the tall. You can't be broad now in this day's Army, I guess—but there had to be all the different sizes.

There were also very few uniform stores for the women at that time. We had Sugarman's down here in San Antonio. We had Miles [military clothing store] in Petersburg. What else? Those were the two big uniform stores that we had. They had a Kelly Lak out here, I think, that they started. We had trouble getting our women, the basic nurses coming through MFSS, into uniforms because they'd have to get their dress blues down at Sugarman's.

MAJ Gurney: Did they feel this mint green uniform would make that easier?

BG Dunlap: They hoped that it would be something that more companies would be willing to manufacture. It didn't happen that way. The manufacturers have to meet military specifications, and they can't make money meeting military, Class A, material specifications. That's what it amounts to. They didn't spend that much time manufacturing low-cost women's clothing at that time.

Finally, after many, many, many sessions on uniforms we agreed on what we would test. Then we had to go through the test period. The evaluation had to be written and then had to be presented to the uniform board and adopted. That was my whole career, I think. (Laughter)

Hospital Whites

We got into the Class A and went through the same thing with that related to material and design, using the same procedure. Where I was really involved, a real concern of mine, was the hospital uniform. Remember, we had worn starched cotton uniforms. The white starched ones. They were long-sleeved and we finally got them to short sleeves. And then we got to the synthetic uniforms, and we were getting into a period when we had the energy crisis and synthetics were getting scarce, so we were going to have to come back with different cotton-synthetic combinations. Then we got into the mix, and into design, and into the laundering of the uniforms because it used to be that you could take your uniforms to the quartermaster laundry and have them laundered. But quartermaster laundries did not have equipment to launder and to press these synthetics. That meant that they would have to buy the quartermaster laundries all new equipment. That wasn't in their budgets. We got into that and how the uniforms came back.

Well, if the nurses then would be responsible for doing their own uniforms, at their own expense, would they get an allowance for doing their laundry? Then we got into the pantsuit.

MAJ Gurney: The white pantsuit or the Class A green pantsuit?

BG Dunlap: Oh, no, we didn't have a Class A pantsuit. I will take that back. We had it only in terms of the field uniform. That's another whole area of uniform development that I have been involved in all my Army life.

But I'm talking about the hospital duty white pantsuit. This is a period in civilian life where women were wearing pantsuits to formal affairs, to everything.

The Army Nurses wanted to wear pantsuits. I didn't really approve of it. But I had to acknowledge that what I thought wasn't always the right thing, the best thing. The other two Chiefs [Admiral Arlene Duerk for the Navy and General Ann Hefley for the Air Force] were faced with the same problem. The Navy had adopted a white duty pantsuit. Working with Alene Duerk, I had the greatest respect for her. She gave me some advice. She said, "Don't adopt one that opens in the front because no matter how many regulations you write, you will have a lot of Brigitte Bardots on your staff who will want to open it at the top button." (Laughter)

You know, "they'll open the top button or they'll hang over." She was so cute when she was telling me this. She was very sincere. But in their testing, they found that it definitely should open in the back. That pantsuit has a zipper in the back and the neck is comfortably low and open so it wasn't a high neck.

We tested the Navy's pantsuit and adopted it. Our regulation on wearing the uniform specified that the pantsuit would be worn only in patient care areas. I felt that the pantsuit was not an appropriate uniform to be worn by the chief nurse of the hospital, who is not involved in direct patient care. I saw the pantsuit being worn by our staff who were bending over beds, working with equipment, working with patients. I could certainly justify going from the short miniskirt to a pantsuit-type uniform in that setting.

If I walked into a headquarters, and I met the commanding officer and the chief of Professional Services and all the other staff at that headquarters, they might wear the white coat over their greens. I felt that the nurse in the white pantsuit was not comparably dressed. If she was representing nursing service at some post committee meeting or another event and the others were in their different uniforms, she shouldn't be in that white pantsuit.

Let's face it; we had some chief nurses who didn't look real nice in them. It was not just chief nurses; we had some nurses that didn't look that nice, the ones that were too fat in the pantsuit. So, the regulations said that it was to be worn in direct patient care areas only. That was enforced.

Likewise, we addressed the wear of the white nurse's cap. I told you I was an old fuddy-duddy. I could certainly appreciate what nurses were saying to me. They didn't want to wear the cap. Many of our collegiate schools of nursing—we were insisting we wanted only college graduates—don't have a nursing cap. Their students graduate without ever wearing a nursing cap because they didn't have them. Then they come in the Army Nurse Corps and we make them wear the Army Nurse Corps cap with their uniform. They sure didn't like that. Well, I still felt that the cap was a distinguishing professional item of the uniform. The Chief of the AMSCs and I didn't agree. The AMSCs were allowed to not wear the cap; it was optional for them. The Army Nurses still wore the caps.

We also had a difference in the physical therapists' uniform. The PTs developed a gold pantsuit to wear in the PT clinics. When we developed a pantsuit to be worn by the AMEDD, we felt all AMEDD personnel should wear it. So they came around to wearing it then. But it was hard for them to give the other uniform up, because they had developed it.

Overcoat and Raincoat

We used to have the double-breasted overcoat and a raincoat that was green. We had to work with the enlisted personnel managers in the total Army who wanted to eliminate the green overcoat and go to just the all-purpose black London Fog. We tested and developed that coat with a zip-in liner. It could be worn in a full range of inclement weather. I went along with that, but I didn't want to completely eliminate the green overcoat. I wanted it optional because if I was standing on a parade ground with the male officers in their green overcoats, because they had not gone to the all-purpose coat, I wanted to have my green overcoat on. I didn't want to have a black London Fog on.

Those were the main items of uniform other than field uniforms. As you go through this procedure, you have tremendous problems developing women's uniforms because we have women working in so many different environments, even more so now. The women working in the line have a BDU as you call them.

MAJ Gurney: Battle dress uniform.

BG Dunlap: It was a field uniform, as we knew it. We had what we called "fatigues" if we were in that area. But we have an additional uniform, and that is the hospital duty uniform. That's our white uniform. But if they're not in the hospital, they're wearing what you have on here [the Class B uniform], or in the field units, the BDUs. Uniforms will always be a problem. Every chief nurse will be faced with it. The circle will continue to go round and round. Someday you will again have the insignia of the Army Nurse Corps on your [Class B] uniform. (Laughter) I think. I may not see it. But it changes.

MAJ Gurney: Yes.

BASIC ENTRY-LEVEL EDUCATION FOR ARMY NURSES

The Push To Open to Associate Degree Nurses

MAJ Gurney: We've encountered the issue of whether we should have associate degree nurses in the military. I know that you dealt with this. We had the experience in '66-'68 with the warrant officer program. That issue continued to crop up: the debate on whether associate degree nurses should be admitted. Why did the issue continue to plague us? What was it that continuously brought the question back?

BG Dunlap: The shortage of nurses. It affected our efforts to recruit. We kept having to face people at the DA [Department of the Army] level and DoD [Department of Defense] who said that we did not need to spend money on recruitment programs like WRAIN and our ASNP [Army Student Nurse Program], because there were plenty of RNs out there. If we would take graduates of AD [associate degree] programs and the hospital schools of nursing, and not

just insist on baccalaureate graduates, we would do fine. I don't know which year we're talking about now, but this was true at the beginning of my administration. By the end of my administration we were able to set the baccalaureate degree as a requirement for commissioning.

But others felt there was no reason for us to spend all this money for recruiting when there were plenty of nurses out there if we would—they would never say “lower your standards,” but that's how I would refer to it, as lowering the educational standards to do it. This also was really pushed by the reserves because, at that time, we were talking about one Army when we talked about the reserves and the active duty. The emphasis was that we're all one Army. Based on that, I said, “If we're all one Army, then the Army Nurses should be equally qualified whether they were on active duty or in a reserve status,” because based on experience I knew that if we had to mobilize and bring those reserve nurses on active duty, they immediately would have been put into leadership positions.

I felt this way about active duty because we knew that if we had a Corps strength of 4,500 and we had to mobilize, every one of those 4,500 would immediately be expected to function in at least one higher level and sometimes more than that. Many of those who were serving as assistant chief nurses or even supervisors would have been sent out as chief nurses of units. This is why the proper educational preparation prior to coming on active duty was important to me.

Then we would need to factor in our continuing education program once they were on active duty. I really felt that one of our big missions in the Army Nurse Corps was to prepare our nurses to function in an expanded role. I have to be careful because we use that term “extended role,” don't we, talking about so much clinically, but they would have to function in an expanded role in terms of areas of responsibility. People working in the operating room would have to go out to become OR supervisors of units. We saw it in Vietnam and every other time we have mobilized. This was my position as far as education was concerned.

There were many AD programs in certain states, and there were reserve officers in units in those states who had a great deal of influence, political and otherwise. I can think of one particular state that had a great deal of influence within the reserves. I think we were having a Reserve Commanders Conference, I guess it was, there in Washington. I was invited to speak. Our Surgeon General could hardly wait to introduce me to one of the reserve generals of the medical center because he was just waiting to see how this fight was going to materialize. Our Surgeon General knew my position, and he supported me. But he also knew the position of this commanding general of this hospital center.

I guess I really should tell you, just for your own information and to really paint this picture, who it was. General Jennings was The Surgeon General. General Jennings is six foot six and tall and slim. The other general was tall but rather robust and he chomped on a cigar. I am five foot two. You can see the picture of me standing between the two of them. (Laughter) Although that's a graphic picture of our physical stature, it relates to the situation because I had to defend a nursing position to two Medical Corps general officers.

MAJ Gurney: Why was a reserve Medical Corps officer so interested in that issue? What motivated him to feel so firmly?

BG Dunlap: His unit. At that time they were so very short of professional staff in their reserve units. There were great pressures put on them to fill their slots. But they couldn't. They were putting the pressure on me to lower the requirements for Army Nurses because at that time we weren't accepting ADs; we were accepting the three-year diploma school graduates, but not ADs. They wanted us to accept the ADs, and we said no.

They also wanted us to allow them to train their own 91 Charlies for their units because they had such a shortage of 91 Charlies. Those two issues came up at every reserve meeting and conference I attended. I visited the various reserve units. They just were having trouble recruiting nurses and 91 Charlies. Their view was, instead of coming up with some positive programs to get quality, it would be easier to lower the standard and take AD graduates, particularly if the administrator of one of those colleges offering the AD program happened to be a member of the reserve unit. So, it was a real political situation there.

MAJ Gurney: When you first described this issue, you also mentioned something about the Army standards related to the education of officers. Were you alluding to a goal, or a requirement in the Army to have baccalaureate degrees for all officers?

BG Dunlap: I felt very strongly that if we were asking for equity for the Army Nurse Corps in terms of promotion and opportunity to go on for military schooling such as Command and General Staff College and other military schooling like that, then we must require equal qualifications. We had fewer baccalaureate graduates for the total strength of the Corps. As the baccalaureate graduates came into the Army Nurse Corps, they were commissioned as first lieutenants, thus given constructive credit for their baccalaureate degree. Those who had less than the baccalaureate came in as second lieutenants. Well, how long could we continue to do that? We began to get more and more graduates of baccalaureate programs who came in as first lieutenants when, to get into other Corps of the AMEDD, some of them had to have greater education, even Ph.Ds. I think in psychology they had to have their Ph.D, yet in the Army Nurse Corps, they came in as first lieutenants or captains.

I felt that we should have equal educational preparation as all other officers in the Army.

MAJ Gurney: What were your greatest obstacles besides the reserve? Was there a focal point in the Department of Defense that created a problem?

BG Dunlap: Yes, DoD. DoD and the Office of the Assistant Secretary of Defense for Health Affairs. There was a staff officer over there who had been there many years and was a retired Army MSC officer. He felt that we should take in anyone

who was an RN who otherwise met the qualifications, that the educational requirements should not restrict it to just baccalaureate graduates.

MAJ Gurney: Were you ever able to achieve closure on that issue? Did you ever feel like you had conquered it, and how did you do that?

BG Dunlap: Yes, as far as accession into the active duty Army. I served under two Surgeon Generals. General Jennings was The Surgeon General when I first went in; then [Lieutenant] General Richard R. Taylor followed him. They both supported me in my efforts. It was General Taylor who really supported me right at the last when I insisted that we not take anyone in who had less than baccalaureate preparation. There was one exception for someone who was highly qualified, with progressive clinical experiences, in those MOS's where we had a critical shortage. I had to be realistic here. We had shortages in OR and anesthesia. The ANC always had that, and until we got our programs going really good, we also had shortages in some of the critical care areas.

So, if we had a nurse who was a hospital school of nursing graduate who had five, six, seven years of progressive experience, they would be an exception. I stress progressive experience because I felt that if a person had been working in a doctor's office for five or six years doing the same thing, that was not progressive nursing experience to me. But some had been working in big medical centers and trauma centers and in the big operating rooms. We made exceptions for the person who had that type of progressive experiences if they were to go into a shortage MOS.

I used the green eyeshade and quill method in keeping records about this. If you remember, recruiting came under AMEDD PERSA. So, in theory, applications for appointment in the Army Nurse Corps didn't have to come into my office; they could be handled over at personnel and I would not even see them. But I didn't want it that way. So we worked out a system that every application for appointment was staffed to an AMEDD person, one of the nurses over there. It would have to go up to ANC Branch, and then it was sent to my office.

MAJ Gurney: Every application? You looked at every application?

BG Dunlap: Not only did I, or the assistant chief, look at every application, but we had a great big ledger, a big accountant's ledger. We wrote down the name, the age, qualifications, all the information and education and so forth. If someone said, "Well, I don't know why she was turned down or where her application is," we could answer the question. Or if they asked The Surgeon General when he was out on a trip or one of the staff officers there, "Well, we've sent in some applications, and we haven't heard—can't understand what the delay is," and so forth, we had an answer. All they'd have to do would be call my office and we could tell them how many had come in, when that person's application came in, where it was as far as in the staffing process and whether we had recommended approval or disapproval, and why we had recommended disapproval if we recommended disapproval.

MAJ Gurney: How many applications then did you see on average? Was it 30 a month, 30 a week?

BG Dunlap: I don't know. We were particularly interested in reserve applications because when The Surgeon General was at conferences and they said, "Well, I don't know why we can't get so-and-so in. We sent applications up there and we didn't get them in." We could tell them why they weren't qualified to come in.

MAJ Gurney: When you're talking about reserve applications, you're talking about Army Reservists asking for active duty?

BG Dunlap: Active duty.

MAJ Gurney: Not necessarily an application into the U.S. Army Reserve?

BG Dunlap: Oh, no, just those wishing to come on active duty. We really wanted to be able to say that out of all the applications that came in, how many did we accept. We didn't have all these computers set up in that office like they do now.

That was one of the rudest awakenings to me when I went into the ANC Branch in 1966. I think I have said this before in these interviews. It was amazing to see how we were using the green eyeshade, quill, and finger-counting method of bookkeeping, working from a printed roster. That was how we got our numbers to respond to DoD, DA, or congressional requests for numbers about anything. I like statistics, as you can gather, and I learned a long time ago that if you can present a statistical picture to men on a staff, you could get your point across much easier than if you try to appeal to the emotions. They understand the numbers. They work that way. When I presented the facts statistically, they could see what the problem was.

MAJ Gurney: So you established a system of criteria for your ANCs, and you had a system to allow individual waivers for those with less than a baccalaureate degree, but that never extended to the associate degree.

BG Dunlap: That's right.

MAJ Gurney: Were there any folks on your staff who you particularly depended on to help you fight that battle?

BG Dunlap: Certainly I utilized the assistant chief of the Army Nurse Corps. We met every morning and we discussed positions that we would take. They were our positions. We didn't always agree, but we could talk it out, and then once a decision was made, this was the position we would take. Then the two of us followed that line of thinking, or action, I should say.

The chief of the Army Nurse Corps Assignment Branch was one person I worked with constantly. She often represented the Army Nurse Corps at

AMEDD PERSA and at other staff meetings when they wanted an Army Nurse. She was the next senior person.

The nurses assigned in The Surgeon General's Office, to my knowledge, all agreed that the goal should be to accept only graduates with a minimum education preparation at a baccalaureate level. To my knowledge, there weren't any who disagreed with that.

The Evolution of the Requirement for the Baccalaureate Degree

MAJ Gurney: That leads very nicely into the next little item I have on the list. That is the baccalaureate requirement. What stages did that requirement go through during your tenure? The implementation of that goal was progressively phased in. Was it phased in in any structured way, or was it just what you were able to achieve at the time?

BG Dunlap: I am trying to think of when the regulation was written. To begin with, it was phased in with what I could get away with. (Laughter)

AMEDD PERSA had responsibility for recruiting and they were pressured to meet recruiting requirements. I think maybe the support was not always there from other than Army Nurse Corps officers. As long as we could meet our recruiting objectives, they really couldn't pressure me too much to lower the standards.

We had WRAIN and we had the Army Student Nurse Program. If the remainder of our recruits could be primarily from the baccalaureate programs and we met the requirements, we were all right. It was when we fell below our recruiting objective that pressure was exerted or the politics would start. When I say politics, it doesn't mean just the Congress or people like that; it was the politics of the whole system related to why individuals couldn't be appointed.

I am trying to think of the regulation. Did we have a year when that was changed?

MAJ Gurney: I have one of the new editions of this year's *Highlights in the History of the Army Nurse Corps*. In '72 I have an entry that says Regular Army officers had to have the baccalaureate degree or proof of progress toward it. In '76 it says all Army Nurse Corps officers would have the baccalaureate degree.

Was it when you came into office in '71 where you began to place the emphasis in recruiting at the baccalaureate level, or did that start earlier?

BG Dunlap: Oh, that started earlier. I think if you look back in our history, 1950 even, Colonel Phillips and Colonel Bryant had said this is what we want. That's when they began to make provisions for some of us to go for long-term schooling. Now you call it long-term civilian training, to work toward our baccalaureate degrees. But there were so few collegiate schools of nursing at that time; it wasn't realistic to put that requirement in.

It was the goal to have all of the professional nurses at least prepared at the baccalaureate level. I really pushed it during my time. I can't give you the exact number of years, but I would say that two of my four years in office we really didn't

accept anyone except graduates of baccalaureate programs, with the exceptions that I have indicated. Now, that may not be exact, but at least it's something like that.

MAJ Gurney: Very interesting.

BG Dunlap: But the regulation was not changed until after I left office. General Parks was certainly a big supporter of this. I left in September and the new regulation went into effect October 1, 1976. We still had WRAIN. The ASNPN had been discontinued. It was discontinued before WRAIN was. I'm almost sure it was discontinued during my time or was in the process of being discontinued, anyway. We continued to have WRAIN graduates.

That was the whole philosophy behind discontinuing those programs. Why do we subsidize nursing education when there are plenty of nurses out there, not prepared at the baccalaureate level, but available for service? That was the position pushed by the Assistant Secretary of Defense for Health Affairs.

Our position was pushed in all three Nurse Corps because the Chief of the Navy Nurse Corps and I agreed that we wanted an all-baccalaureate Corps. The Air Force Chief did not agree. It was ideal, but she didn't think it was appropriate for her Corps at that time.

We had not moved into ROTC yet. So, if you discontinued WRAIN and you discontinued ASNPN, you had no more input from those two programs. Thank goodness I was gone because there were no programs to prepare nurses, and they had to really get out and concentrate on recruiting graduate nurses or new graduates of baccalaureate programs.

Then ROTC came around. We had talked about it during my time, but we hadn't had to move into it. There was still quite a fight on for the spaces in ROTC, and the argument was that you needed to put people into ROTC who would be commissioned in the combat arms. Some of our medics were ROTC too—but that was to prepare them as commanders. Army Nurses were restricted, by law, from commanding anything except within our own Corps. So, they could justify in their minds that we did not need any spaces for nursing students.

The people who followed in years, [Brigadier] Generals [Madelyn N.] Parks, [Hazel W.] Johnson, and [Connie L.] Slewitzke, have done a tremendous job, with the people who have been on their staffs, in meeting the recruiting requirements. And our next Chief of the Army Nurse Corps [Brigadier General Clara Adams-Ender] also, because she was there at USAREC [U.S. Army Recruiting Command] when tremendous requirements were placed on them to find graduate nurses of baccalaureate programs. They did it. And we didn't subsidize their education.

MAJ Gurney: So when those programs faded away, they left a big gap, but they filled that gap.

BG Dunlap: They filled the gap. I think the only subsidized program we have now is the ROTC program.

MAJ Gurney: The exception is the STRAP [Specialized Training Assistance] program for the Army Reservists, which is new.

Let me go back to the baccalaureate degree for another question. What role did the nursing professional organizations play in the effort to bring baccalaureate nurses into the Army Nurse Corps?

BG Dunlap: This has two problems, really. We still have that controversy in the nursing profession—period. Thank goodness, though, they have at least issued position papers. They issued one in 1960, but it wasn't effective. I think their position papers are more forceful now, that the minimum educational preparation for a professional nurse would be a baccalaureate degree.

We specified that it should be a baccalaureate degree from an NLN-accredited program. That was another battlefield for me because there were programs throughout the States that were not NLN-accredited, usually not the collegiate programs, but the AD programs and some of the hospital programs. The same people who said that we don't need to have baccalaureate-prepared nurses were saying, "Why should we require NLN accreditation?"

I invited leaders from the NLN to come down. I had been on one of their committees at the national level. I invited them to come down, and I set up a meeting in The Surgeon General's Office with The Surgeon General and members of the staff, so that they could explain what the accreditation process was and what it meant. It was Dorothy McMillan who came down. We had served on a committee before. She explained what the process was, what they looked for when they went out to accredit, and why it was important if we were to have any standard against which to measure quality.

As far as the ANA, I had very good working relationships with different members, and I know Jo Elliott, the president of ANA. She served two consecutive terms, bless her. I don't know how she did it—but anyway, she was a big supporter of the Army Nurse Corps.

There are others I met through committee work and other activities who I felt I could call. Inez Haynes, the former Chief of the Corps, had been executive director of the NLN, and I could always call on Inez.

Having worked on national committees as a resource person for workshops, I knew some of these people and could call on them for advice, support, letter writing, phone calling, things that might be needed. Any time I wanted them to come in to meet with nurses or at our conventions to get the group together, they were more than happy to do so.

I remember, before I was Chief of the Corps, we were at a meeting in Detroit and had a breakfast. I was a speaker at the head table. We had representatives from ANA and NLN there at that breakfast that morning. They really supported us.

My experience with ANA and NLN has been that support is a two-way street as it is with any organization. If we isolate ourselves from them as an Army Nurse Corps, we can't expect them to come to offer support. We have to make known to them our problem areas and where we need support, and we have to remain involved in ANA activities.

Licensure

Licensure was something else that we always had to work for. We wanted our people to have current licensure to practice. I had to defend that, because we were the only Corps in the AMEDD at that time that required that. Our physicians did not have to have licensure to practice or to get appointed. They do now, though, don't they?

MAJ Gurney: They sure do. (Laughter)

BG Dunlap: But look how many years that took.

MAJ Gurney: I know.

BG Dunlap: I would have to defend our position. "Why do you require current licensure of the ANC to be commissioned, when the doctors don't have to?" How many times I heard that!

To me, this was a standard. If you don't pass the state board exam and you're not licensed to practice, or if you have been negligent and not kept your license up—because it's so simple to keep your licensure up—that would reflect to me your lack of commitment to the profession, and I didn't want you in the Army Nurse Corps. So, we insisted on that licensure.

I used to say; "Now I lay me down to sleep. Thank you, Lord an NLN-accredited program."

I was defending NLN accreditation constantly. It was very difficult. Some people in the line—I shouldn't say just the line, but medics, other than nurses, and DoD, never really understood it or accepted what we were trying to do. "Why do nurses have to be different?" I heard that too. I said, "Well, we are different." (Laughter)

You're still fighting those battles, aren't you?

MAJ Gurney: We sure are. The profession is.

BG Dunlap: That's right. It's going to be interesting to watch the change in the terminology in the profession and the impact that is going to have on military nursing. They're talking about the "professional nurse" and the "technical nurse." Now, who was it that started that? I think Louise McManus maybe, at Columbia, was talking about professional and technical nurses at the beginning of the development of the AD programs. The AD graduate would be the technical nurse, and the graduate of the baccalaureate program would be the professional nurse.

I could see where those who were fighting me were coming from, because if we all took the same licensure exam and became RNs, an RN was an RN. I tried to point out that the states did the licensure. Nurses took an NLN exam, but the states did the licensure. Each state at that time could indicate what the passing rate was for that particular state. So it varied. But it was difficult to defend the position. You could see why.

MAJ Gurney: Sure.

BG Dunlap: An RN was an RN. What difference does it make? A doctor is a doctor. They were talking about taking osteopaths into the Army, and then someone said, take chiropractors in, and they finally got the osteopaths in. That was a long battle, and just a few osteopaths got in. I don't know how many they have in today. At that time an MD wasn't an MD. A doctor wasn't a doctor, but a nurse was a nurse.

MAJ Gurney: Yes. That's right.

BG Dunlap: It was a little bit of a double standard.

Threats to WRAIN

MAJ Gurney: You talked a little bit about WRAIN, and I thought we could complete our discussion with WRAIN. During your tenure, there was the movement to reevaluate the cost-effectiveness of WRAIN and perhaps reduce the subsidization of the WRAIN graduates to a two-year subsidization as opposed to four-year, and then finally, to eliminate the program. Could you discuss that and what was going on through your office related to WRAIN?

BG Dunlap: This all goes back to the DoD budget and pressure to commission associate degree RNs. If we could get plenty of nurses, why spend money on subsidizing education to prepare them? Just the things I have been talking about.

Our position was, WRAIN not only prepared a baccalaureate-level nurse but also, since they had their last two years at Walter Reed, when those youngsters graduated and came on active duty, their orientation to the Army medical team had already been completed. They could move in quickly. I saw this as I visited the stations on staff visits. The commanders would say with pride, "Oh, we got one of your 'WRAINdrops' here."

Of course, there were good "WRAINdrops" and there were not-so-good "WRAINdrops," but they were really an outstanding bunch of people, those young nurses. They had been at Walter Reed. They had worked in a military setting. They knew the AMEDD team, and it was easy then for them to move right on into their first assignment once they had completed their orientation course. It was interesting to me then—what did we later start, the Uniform Services University, whatever you call it?

MAJ Gurney: Uniformed Services University of the Health Sciences.

BG Dunlap: They used the same arguments that we had used when they started that program, because their military physician trainees also got specific military experiences. They go in the summertime and get their experiences in a military setting. So, when they graduate, they move right on to start practice. They are really two steps ahead of the person coming directly out of a civilian school with no prior military experience.

MAJ Gurney: Wasn't there a manpower aspect to that desire to reduce WRAIN? All of the students in school counted against Army strength and they wanted to increase the number of combat divisions, so they needed those authorizations?

BG Dunlap: Tail to teeth.

MAJ Gurney: As long as those numbers were counted against Army strength, they couldn't have their division.

BG Dunlap: This was during General [Creighton W.] Abrams' time as Chief of Staff. Tail to teeth; they were trying to come up with every space they could. They're doing that again now, aren't they? But they're not calling it that. They wanted to clear every space that they could in the "support" troops to convert them to "teeth," or combat, troops. This was a consideration because the students were on enlisted status until they graduated. They were occupying many enlisted spaces. But they were in school and not "contributing" to combat or defense during that time.

MAJ Gurney: You were saying that all of the positions were examined.

Civilianizing Nursing Service

BG Dunlap: Throughout the Army all the positions were examined. Those of the support troops were examined in depth to identify the ones that could be converted to combat positions. You can also, here, get into the issue of civilianizing the Army Nurse Corps. That was a constant battle. It sounds like I was in combat all four years as Chief, doesn't it? (Laughter)

MAJ Gurney: Were you battle-fatigued?

BG Dunlap: I think you were more tactful than I. At the beginning you said "the issues." (Laughter) I thought, "Those were issues?" (Laughter)

MAJ Gurney: Those were "battles!"

BG Dunlap: Sometimes we felt like we were battling them, but they were issues, I guess you'd say. We were always faced with converting military nursing spaces to civilian nursing spaces. This went along with the baccalaureate and accreditation as one of the constant issues that we had to argue because they were looking for more military spaces and officer spaces since all Army Nurses were officers. They were looking for officer spaces that could be converted to the line. Why not have civilian nurses and give those military spaces to the line? Staffing in many of our Army hospitals was at the point of 50 percent civilian and 50 percent military. We were in the situation then where we had a civilian nurse who perhaps had years of experience in nursing, and we bring in a young Army lieutenant and a recent graduate of a program or with a year or two experience. The Army lieutenant becomes head nurse of the unit because we wanted all of our military nurses to have the

experience of head nursing to prepare them. Head nurse experience was important to career development. But it was difficult to deal with that situation. With 50 percent of our staff in civilian status, we didn't have to put the young lieutenants or captains in as head nurses of wards where we had civilians well qualified, maybe not educationally, but clinically, for those positions. We sure had to depend on the interpersonal skills of our chief nurses to handle situations like that. We forced them to do it.

MAJ Gurney: It wasn't necessarily a popular move.

BG Dunlap: No, it wasn't. It wasn't. And I knew it. But I was responsible, by regulation, for all of nursing service in the Army. I was also responsible for the career development of the Army Nurse Corps officers, and I had to think in terms of that, going back to our mission in peacetime, which is to prepare for wartime.

Then there were other issues related to civilianizing the nursing force. It was visible in many of the different hospitals. We have some of the most loyal, dedicated civilian nurses working in our hospitals. We have others who are less dedicated. Consider the age-old problem of the nurse who calls in at 2:00 that she is not able to come to work for 3:00 to 11:00. Well, who then covers the shift 3:00 to 11:00? Because of budget restrictions, you can't call another civilian nurse to come in from her days off or from leave time or from something like that. So the Army Nurse either goes off at that time if she's scheduled to go off at 3:00 and someone else stays on and covers a few hours and the Army Nurse comes back on, or an Army Nurse who's on her day off is called to come back.

This happened a lot. When civilians comprise 50 percent of your staffing in a hospital, the chief nurse has a great challenge just to provide staffing without all of these different roadblocks put in the way by policy made at DA level.

I've often wondered what it is like now, with so many of our military nurses married and having families. The chief nurse must have a heck of a time staffing, because the children are going to get measles and mumps and chicken pox and runny noses, and the children who are going to get sick are not all going to be children of civilians. They're going to be children of military too. So, what happens when "Military Mama" has to stay home with Johnnie?

MAJ Gurney: Did you have any desire to reverse that trend toward civilianization of those nurse slots?

BG Dunlap: Yes. Yes. I wanted to reduce the percentage. I did not want to eliminate them entirely. We need civilian nurses. They provide continuity in a hospital. You were stationed here at Brooke. You could probably identify some of the civilian nurses. I knew one who was in the burn unit. Vivian Miller was up there for 20 years or more. She provided that stability, continuity in nursing care and nursing service, there because the military was continuously changing.

So, you need people like that, but by the same token, the percentage cannot be as great as 50 percent, in my opinion. It can't be that large if we are going to be

able to carry out our mission of preparing our Army Nurses and providing them progressive assignment experiences and giving them an opportunity to go to school, to participate in continuing education. You can't do it with that without some percentage of civilian nurses.

MAJ Gurney: You can't afford to have the nurses away from the bedside, yet some Army Nurse Corps officers had assignments that placed them away from the bedside.

BG Dunlap: If you have a larger percentage of Army Nurses, you can cover those absences at no increase in budget. But if you have to cover those absences with civilians, you have an increase in budget.

MAJ Gurney: And the decrease in morale among Army Nurses.

BG Dunlap: That's right. And you also have to think about the morale of the civilian nurses, too. You know, it is regrettable that the Civil Service policies relating to professional nurses and nursing assistants in military hospitals are not always worked through in coordination with the military. It's done independently. Civil Service sets up its own standards. The military sets up their standards. But you work in the same environment. We made some efforts toward that end. The Chief of the Army Nurse Corps made some effort to get involved. The other military nursing services and the Federal Nursing Council wanted to get involved in the development of standards for civilian nursing assistants. We could give all the advice we wanted to, but ultimately, they did what they wanted to. Then those individuals were hired through one system to work in our hospitals. The people who we have trained, professional and nonprofessional, have met different standards, yet we have to work in the same environment and meld the two groups together into a staff. It can be done, but it's more difficult because, back to education, we were requiring a baccalaureate of military nurses, but the civilians were not required to have the degree.

I doubt if they do today, do they? The civilian nurses employed through Civil Service don't have to have the college degree. That disparity just gives more ammunition to people who can't understand why we require it in the Army Nurse Corps. They're working side by side on the same ward, the same unit, and that civilian nurse is the best darned nurse we ever had on that unit. She's there year after year after year, and everybody comes through there and sees what a tremendous nurse she is. I am not being facetious. I'm being honest about it. But she doesn't have a baccalaureate degree. They ask, "Why do we have to have Army Nurses with a baccalaureate degree?"

Oh, how many times have I been up there on my five-foot-two to defend that?

MAJ Gurney: And we all do.

BG Dunlap: And you still do.

REVITALIZING CAREER PLANNING

MAJ Gurney: When I was looking through some of the literature published by the Corps during your tenure, I found a list of goals that you wrote for 1972. Some of those we have already talked about. The Army Nurse Contemporary Practice Program, we've already talked about that. But you inserted a goal saying that you wanted to revitalize career planning. What did you mean by that goal? What was on your mind?

BG Dunlap: All right. Remember that I was chief of the Army Nurse Corps Branch (as we called it then). It became Career Activities Office after that. But at that time it was ANC Branch and had responsibility for the assignment, career planning, and training functions for Army Nurse Corps officers. It was during that time that they attempted to divide career planning to make it separate from assignments.

Separating the Career Planning and Assignment Functions

They brought [Lieutenant Colonel] Lucille Fisher in to be chief of the career planning function. Marge Wilson was next after her. She may have already been in the office at the time.

MAJ Gurney: About what time was that?

BG Dunlap: Lucille Fisher was brought in when I was chief of the Assignment Branch. That would be '66 to '68.

This goes back at the beginning in career planning. Back even to Colonel Bryant's term, [Captain] Harriet Werley, and [Lieutenant Colonel] Graham Price. It was this group that developed the idea of doing career planning. As an individual Army Nurse Corps officer, I didn't know what they had planned for me. Of course I know it isn't a one-way street. It takes two people to plan a career. What do you want? What do they think you have the potential for? What are they prepared to do to utilize you in appropriate assignments and provide you educational opportunities?

Until that time there were individual efforts to do career planning. But as chief of Assignment Branch, I felt so very strongly that we should do career planning to the extent that we identify potential and that we really work with the individual to try to plan their career.

When you looked at other Corps within the military, there was a planned progression of assignments for officers. We didn't really have that as formalized as in some of the others. We had nurses who wanted to stay in a medical center. "Don't you dare move me out of a medical center." Others wanted no part of medical centers. They wanted to stay at MEDDACs. I felt that for career planning, they should have both. We were using the term "homesteading" for them. (Laughter)

There were some people who had homesteaded at Walter Reed, at Letterman, at Brooke, or at some other facility. There were others who had gotten all of the

MEDDAC assignments they wanted and therefore never had an opportunity to move into a medical center. I felt that we should plan careers as we looked at their assignments and also identify those with potential and try to put them in assignments that developed that potential. Remember now, I had taught at MFSS for five years and most of the Army Nurse Corps at that time had come through there at some time or another. We could identify students with good potential there. I recall people who I put into assignments who said, "I don't think I'm ready for that yet." "I think you are, and you'll never know unless you try it."

I was pushed into assignments that I wasn't sure I was qualified for, and I pushed others into assignments. Being a graduate of the Hospital Administration Program and the one-year residency, I felt that a graduate of the Hospital Administration Program should have an assignment after that as a nurse methods analyst. To me, it was just so clear. Perhaps it wasn't as clear to others, but it was clear to me.

Some of them didn't want to be NMAs and I'd say, "But I can see this as progression. You've been doing your residency. You move into an NMA position where you are solving these problems in a staff, as opposed to an academic environment. There's nothing that prepares you better for a chief nurse position than to serve as an NMA because you really get to know the whole hospital and you are conversant about what goes on in a hospital."

This is what I was thinking about when I was talking about revitalizing career planning.

Recruiting: From my background in recruiting, I felt that we had to identify people who could go into recruiting, and convince them they could go into recruiting. We had to support them once we put them there. Anyone who has been on recruiting has such an appreciation of what our resources are. As you move on into Chief of the Corps, or the chief of ANC Branch, the individual knows what's out there. They're going to be making policies, recommendations, establishing recruiting programs, and so forth. Well, they know what's out there, what the situation is.

That was revitalizing career planning. [Colonel] Edie Nuttall was chief of the ANC Branch. [Lieutenant Colonel] Sandy [Cassandra] Smith was over in Career Planning. [Lieutenant Colonel] Katie Galloway was there awhile. [Lieutenant Colonel] Edith Knox was also there. We just had some tremendous people in Branch. They could concentrate on looking at an individual's career and then coordinating with the assignment people to direct the assignments that this individual should have to really provide them with career opportunities and appropriate career development.

MAJ Gurney: So, the career planners did not necessarily have assignment authority, but they had input into assignments?

BG Dunlap: That's right. That's the theory.

MAJ Gurney: Did it work?

BG Dunlap: It depended on the individuals. If a person in assignments has to have an operating room nurse at a certain station, and perhaps the career people felt that she should go to school, or she should perhaps have a teaching assignment in OR, the assignment officer may say, "But I need her at so-and-so." That's a conflict that had to be resolved.

MAJ Gurney: Did those two functions remain separate during your entire tenure?

BG Dunlap: They were in the same office.

MAJ Gurney: They were in the same office, but the individuals had one or the other responsibility, not both?

BG Dunlap: Yes, but the chief of the Branch oversaw both functions. We had individuals who just served as assignment officers, and others who served in career planning.

MAJ Gurney: Were there any barriers to the success of that program other than individual nurses who wanted to keep their little profiles where they wanted them?

BG Dunlap: Yes, staffing requirements interfered with that. We had Vietnam going on. Vietnam was a 12-month tour. We had 900 nurses in Vietnam at one time. We had to constantly think, "Now, when that nurse is ready to come back from Vietnam, I have to have someone to replace her. Plus, I have to replace this one over here before that one gets back."

So, that had a big impact and interrupted some career plans being developed by the people in career planning. We had to think in terms of getting them to school, getting them to the career course. There's the orientation course, the career course, and progressive assignments along the way. We had to get them out for long-term civilian education or for some of our clinical courses, nurse clinician courses, and so forth. To do that all in 20 years plus some overseas tours, there isn't enough time in a career.

MAJ Gurney: No, there isn't enough time.

BG Dunlap: We also had a restriction for the length of an assignment in assignments or career planning. I think the restriction was four years for an assignment in The Surgeon General's Office. I know by law that it is for the Chief of the Corps. Is there still a restriction on how long you can stay in The Surgeon General's Office or at a DA position?

MAJ Gurney: I don't know of one.

BG Dunlap: A restriction of consecutive years?

MAJ Gurney: I don't know of one. I do know that the tendency is to move toward making assignments longer.

BG Dunlap: Budget.

MAJ Gurney: Yes, due to the budget.

BG Dunlap: That always influences everything.

But at that time, you could only serve so long in The Surgeon General's Office and then, of course, you could go do a little overseas tour or something and then come back. That happened in other Corps, but normally we think in terms that if they were there three or four years it would be time to move. We had to be concerned about their career planning too. The people in those senior positions moved into chief nurse or assistant chief nurse positions or they became directors of programs or something like that.

If someone is responsible for your career planning for four years, and then someone else comes in for four more years, and you're going to be in 20 years, well, you've got five career planners. Those career planners are not always going to be there four years either. Your MOS may change, and so there might be someone else then taking over the responsibility for planning for your career within that MOS.

The Army Nurse Corps worked differently than the Medical Corps. We had the clinical consultants—is that what they call them?

MAJ Gurney: Consultants to The Surgeon General?

BG Dunlap: Yes, consultants to The Surgeon General in their particular clinical areas. This was another issue related to staffing and trying to get more officer spaces. Why did we in the Army Nurse Corps require Army Nurses to staff the ANC Branch, why couldn't MSC staff it like they did in the Medical Corps Branch? That's one of the reasons they had the consultants. The MSCs who were staffing the Medical Corps Branch didn't make the professional decisions about where doctors were going to be assigned. The consultant in OB/GYN discussed assignments with the action officer [MSC] in the branch to determine where they should be assigned. The MSC was the action officer. We didn't do that in the Army Nurse Corps, so, many times, we were questioned about why we needed an all-ANC staff in the ANC Branch.

MAJ Gurney: But our consultants weren't making those assignment decisions.

BG Dunlap: No. We didn't have any consultants, to begin with. We gradually developed a team of consultants. Mercedes Fisher was the consultant for Army health nursing and Sally Travers did it in OR nursing and Ruth Satterfield covered anesthesia.

MAJ Gurney: Those were dual-hatted positions?

BG Dunlap: Oh, yes.

MAJ Gurney: Did we have a full-time nurse consultant at that time?

BG Dunlap: No. No. These people were working in the hospitals. For instance, for the Medical Corps, he might be chief of OB/GYN at Walter Reed or something. But our nurse consultants were not assigned in The Surgeon General's Office either. Those first three were assigned out in the different hospitals. Those were the first three nurses to have the A prefix too.

MAJ Gurney: Did you feel you had success with your program to revitalize career planning?

BG Dunlap: Yes, but not total success.

MAJ Gurney: How would you measure that success?

BG Dunlap: Well, in what happened to them after I left. The people whose careers we had a part in, and I say "we" because it wasn't me, it was the ANC Branch and the others there involved in career planning and assignments. It was what happened to them and their careers. We must have had some success because two of them have become Chief of the Army Nurse Corps. These officers have moved into senior positions.

Since I've retired, I've watched as the people we had some impact on, guiding their education, their assignments, have moved into the senior leadership positions in the Corps. They became the leaders in the Corps, the chief nurses. I'll give you an example: little Janie Carson. "Little Janie Carson" became Colonel Carson. She was in the Branch, but I can remember when she was going out to First Army to be chief nurse at Kimbrough [Army Hospital, Fort Meade, Maryland], she wasn't so sure she was ready for that job. Well, I knew she was ready for it. I thought she was ready for it. She made a tremendous chief nurse out there.

The commander would tell me all the time, "Thank you, thank you, thank you." And Janie, one of our full colonels now, had that job in the National Guard and really was able to do such a tremendous job there. And of course, General Connie Slewitzke and General Adams-Ender, who will be the next Chief, they were among the different officers whose careers we were concerned with during the time. They're not the only ones. There are many different people you can name along the way.

I remember Katie Galloway, rest her dear soul, had been chief of career planning. When she was ready for reassignment, we moved her to Kimbrough to be chief nurse out there. She really thought that was taking a step down, to go out there. I felt differently because I had been chief nurse at First Army and I knew that Kimbrough was under the flagpole of First Army headquarters, and many of the patients out at Kimbrough were from First Army. That's when it wasn't scaled down as much as it is now. I have felt very strongly about the relationship of the

AMEDD and the line, and I knew if the commanding general out at First Army and his staff had a great deal of respect for the chief nurse over at Kimbrough, it couldn't do anything but help the Army Nurse Corps.

Katie was that kind of person that they all just loved and respected. She thanked me later for sending her into that job. Then she moved from there to become chief nurse at Walter Reed and she did such a fine job there, as she always did. She was such a clinician.

This is what I mean about how you can measure success. I'm sure there were failures too along the way. I think of one particular one. I like to think of it as disappointment instead of failure. I won't say any names, but this was an individual who had been a student when I was teaching, had great potential, and went ahead and developed that potential along the way. But then this individual's career goals were not compatible with the ANC career goals for her, and as a result she got out of the Corps. That was a disappointment there.

MAJ Gurney: You couldn't really touch everyone with this program.

BG Dunlap: Oh, no way.

MAJ Gurney: But you tried to identify those folks who could benefit, as well as the Army Nurse Corps could benefit, from some guidance for their careers?

BG Dunlap: Copies of the efficiencies came into the Branch. I'll go back now to when I was chief of the Branch. Efficiencies came into the Branch, and we had a file on each person. I am thinking of Ski Straley. Colonel Straley was the assistant chief of the Branch when I first went in. We had Jean Barcus and Anna Antonicci there. They knew those records. They knew those people. That's when they were doing career planning and assignments too. If you needed someone to put in recruiting, or if they looked at an efficiency and saw that the chief nurse recommended them for recruiting, they'd assign that person to recruiting.

I'll give you an example for recruiting: Betty Rogers retired after being chief nurse at Brooke Army Medical Center. She was a tremendous chief nurse. As a young captain out at Fitzsimons, [Colonel] Ruth Taylor, who was chief nurse, recommended her for recruiting on an efficiency. Either Jean or Ann picked it up; I don't know which one was reviewing her record at that time. We needed to assign somebody to recruiting in the Boston area. They brought the record in to me and said this is someone who the chief nurse has recommended for recruiting. They said they'd reviewed the record, and they wanted to contact her to see if she was interested in recruiting. Is it all right if they contact her? And if so, can they assign her to recruiting? That was before we had AMEDD PERSA. So they knew their people, and as they reviewed the efficiencies, they knew the recommendations made by chief nurses.

By the same token, they knew the weaknesses, if you can ever get anyone to put the weaknesses in an efficiency. They could highlight those weaknesses and consider whether we should send them to school. An application might come in

from someone to go to school, and they got out their records and reviewed their records. Maybe this is a person that hadn't been recommended for that type of thing, although the application from where they were at that time might include a recommendation.

So, they really knew their staff. After Ski left, then Maude Smith came into assignments. Then we had Jean Barcus and Ann Antonicci and Maude Smith. They knew the people. Officers were divided by MOS. Then, when I was Chief of the Corps, although the organization was different because we had AMEDD PERSA by then, it still functioned much the same way. Edie Nuttall was chief. Even under that organization, each of the assignment or career planning officers knew their people because they worked with just their group by MOS. Any time we reviewed an efficiency and someone has recommended this person for recruiting, or for long-term civilian training, or for teaching, for anything like this, we make a note of it. We're constantly looking for people in those key assignments. When the requirement comes up, we knew the people who have been recommended for it.

My position was: could someone other than a nurse do that? Would that person have the understanding, the appreciation of that assignment? I don't think so.

MAJ Gurney: It worked. You won. (Laughter) Another one of your goals for that—

BG Dunlap: You scare me now, telling me what my goals were.

COLLABORATION WITH OTHER CORPS

MAJ Gurney: Your goal was to increase involvement with other Corps in planning, designing, and delivering health care services. What did this represent? Why was that a concern?

BG Dunlap: This was based, again, on my experiences, assignments in education, and in particular in the Hospital Administration Program, where the different Corps worked together. Then in our residencies we saw how some places did it and some didn't. Then when I was back teaching at the Medical Field Service School, we really had to work together in planning the programs down there—the development of POI [Programs of Instruction] and so forth for the different courses. Then as chief nurse in Okinawa, I realized the importance of the nurse as a member of the total staff. She was not just one who concentrated on nursing, who gave the commander the report in the morning and then went on her merry way the rest of the day to let Plans, Operations, and Training plan what was going to happen in the hospital. They would decide where they were going to move beds and what they were going to do here and there, leaving the chief nurse uninvolved in it. I was fortunate because I had two different commanders in Okinawa who depended on the chief nurse, and as a result I was included in the planning functions like that. I saw the importance of it.

When I was out at First Army headquarters, the surgeon, Colonel Pixley, relied on me as his chief nurse. He included me in his staff planning for First Army and any programs that were to be initiated.

When I went in for that short tour at Walter Reed, as chief nurse, we were involved in planning for relocation of patients as they tore down the back wards to make way for construction of the new hospital. This was quite an exercise. I recognized the importance of planning, but it wasn't easy to get the whole crew together.

When I went into The Surgeon General's Office, I felt that some of the planning for the future of the Army Nurse Corps had been done unilaterally.

MAJ Gurney: By folks other than the Army Nurse Corps?

BG Dunlap: By Army Nurse Corps to the exclusion of others.

MAJ Gurney: You were talking about the ANC's development in staff planning and delivery of health care services. What you were really describing was really a collaborative relationship within the AMEDD.

BG Dunlap: Yes. It goes back to the principle I've mentioned over and over. All my experience as a graduate of the Hospital Administration Program and doing the residency and the assignments that followed taught me that the chief nurse cannot isolate herself from the rest of the staff. She is a member of the commander's staff, and she can't just isolate herself into the nursing care area. She has to work with and have an appreciation for the responsibilities of the chief of Food Service, of Medicine, of Anesthesia, of all of the different departments within a hospital or at the headquarters level, such as FORSCOM [Forces Command], TRADOC [Training and Doctrine Command], U.S. Army Recruiting Command, and certainly then at The Surgeon General's level.

The Surgeon General held staff meetings each Friday. He had a big staff meeting around that table down there with all of the chiefs present. I felt that I didn't want to have anything presented at that staff meeting that related to nursing, or would have an impact on nursing directly or indirectly, that I hadn't been involved in planning. I wanted the other members as they were working on projects within The Surgeon General's Office to come for my chop on any paper. I didn't want to be faced with something that had been staffed through The Surgeon General's Office and signed by The Surgeon General that I didn't know anything about. This had happened prior to the time that I came into the office.

When [Major] General [Robert W.] Green was our Deputy Surgeon General, any paper that came into his office relating to nursing service, not just Army Nurse Corps but nursing service, if it didn't have my chop on it, his question would be, "Has Lil seen it?" He might call me and ask that question. If it did not have my chop, he would then turn it back for my comment on it. He wanted my comment on whatever came through. By regulation, I had responsibility for nursing service. Nursing service interacts with every other element of the AMEDD.

I wanted the Army Nurses assigned in The Surgeon General's Office to have that same type of relationship, not just me as Chief of the Corps. As Chief, I wanted any of the nurses working in education and training or any of the OTSG staff elements to have that same freedom to go to anyone in The Surgeon General's Office to ask for an opinion of the impact of something on the other people in the other Corps. You can't go in on every piece of paper, naturally, because not every issue has the direct impact we're talking about here. But to me—and I don't want it to sound like a trite expression—we talked about an AMEDD team, and the AMEDD team philosophy has to function as a team at all levels of the AMEDD organization and particularly at The Surgeon General's level, where policy is being established.

I certainly didn't want any policy established for nursing or enlisted training if I hadn't developed some knowledge of it and had an opportunity to put in my recommendations for consideration by the one who finally had to make the decision.

MAJ Gurney: When you were talking about enhancing the relationship of ANCs in inter-staff planning, even down to the staff nurse level, besides coordinating actions, how else would you want this ideal or this goal implemented? How else did you picture it could be implemented? Would it have to do something, perhaps, with committee work?

BG Dunlap: Well, you mean nurses serving on committees? Absolutely. Whether you're talking about committees within The Surgeon General's Office or throughout the AMEDD, absolutely. I've discussed some of the areas earlier. Consider the nurse assigned on the IG team. I know we've talked about that. The nurse methods analyst is an example of an officer who needs to be on a wide range of committees. These are assignments in areas other than nursing service.

Now we have people focused on quality assurance, research, and all elements of health care. I certainly felt that in planning in all these different areas, I wanted the nursing input because I looked at it as health care, and nursing is part of health care. If you have a committee that is going to discuss health care, you should have nurses there on that committee.

So, certainly, on committees, you certainly don't have to have nurses on every committee, but I was fortunate. I was blessed to have Edith Nuttall because Edie Nuttall then became the assistant chief of the Corps. Colonel Bonnie Whitelaw and Colonel Straley both functioned the same way. But particularly Edie Nuttall kept excellent notes and records. Other staff officers in The Surgeon General's Office would call or come see Edie and ask her, "You remember that meeting we sat in on. Who said this, or what was his opinion?" Edie would pull out that little old notebook and turn to that meeting and she could tell them what happened at that meeting.

That's what I am talking about, the working relationships that could be established, so that we respected each other's opinions. We didn't always agree with them, but we respected them. They respected Edie Nuttall. They knew that whatever took place in that meeting, Edie Nuttall had a record of it, and it would be an objective record. They also knew that she would share it with them.

MAJ Gurney: How would you measure the success of your attempts to implement that ideal?

BG Dunlap: I certainly felt that the members of my immediate office, the Chief and the assistant chief of the Corps, had that type of relationship. With the deputy surgeon general insisting that I chop on every nursing-related paper, I knew we'd achieved it. With the organization of AMEDD PERSA, it became more difficult. The commander of AMEDD PERSA really felt that he didn't need to staff things through my office. He felt he could make those decisions since he had nurse personnel within AMEDD PERSA. This was particularly true when the issue pertained to enlisted personnel. They had staff elements over there concerned with enlisted training and enlisted personnel who felt they didn't need to come to the Army Nurse Corps. But the deputy surgeon general felt that they did, and so did The Surgeon General. Therefore, we provided input. People defined its success.

MAJ Gurney: In your discussion of this goal you mentioned the AMOS study [Army Medical Officers Structure] as a symbol or an indication of the success of that program. You also mentioned the patient care system. Was there a patient care system study or implementation of a new system for patient care?

BG Dunlap: What we were trying to do was to get categorization of patients according to nursing care requirements. When I was in the ANC Branch, Edie Nuttall was in what was the equivalent to the NMA position. We were attempting to get that categorization process updated.

PHYSICIAN-IN-CHARGE PROGRAM

MAJ Gurney: Okay, if we could move on. We talked earlier about the Physician-In-Charge Program. I think there are a lot of hidden issues related to this movement to have ward officers, et cetera. What was the controversy on that issue?

BG Dunlap: Let me give you the genesis of the program. [Lieutenant] General Richard Taylor was our Surgeon General. He called me into his office one day and pulled out some papers from the bottom lefthand drawer of his desk. He had been out on a visit. He didn't go out on many staff visits. The deputy surgeon general went out instead. But he had been out on some visits and at a conference. He was concerned about complaints that he got from the physicians that they had nothing to say about what was happening on the wards and there was constant change in nursing personnel. He said, "Lil, you remember when we were in hospitals we had ward officers. We had a ward officer, a charge nurse, and a wardmaster, and the three of us worked together and ran the ward." Of course, when we did that we were charged with all the linen and custodial service. We had to inspect once a week and check the latrines. The ward officer checked the linen closet and we would have to do other things. He didn't intend

that to be what we did at all. But they really worked together as a team, the ward officer, charge nurse, and wardmaster.

General Taylor said, "What can we do to get that concept back?" He recognized that the nurses, at the same time, complained to him that there is no doctor in charge. They have so many doctors, interns, residents, and different staff people coming on the ward, each one having a different patient. But there was no one person to give them an order when they needed it. "I can't get orders, I can't get a patient discharged because I can't find the doctor to sign the order."

So, he was getting it from physicians and nurses, too. He said, "It seems that we should have some person in charge." I said I was convinced that the nurses were in charge anyway and ran the units. But I appreciated what he was saying. But how are you going to do that? He wanted to try to go back to the ward officer, charge nurse, wardmaster concept in a setting that was so complex. It was kind of like the operating room and the recovery rooms or post-anesthesia rooms. A decision had been made some years ago that the anesthesiologist would be the one who would indicate when the patient could leave the recovery room because, there, they had experienced the same thing. Each patient had a different doctor, and the nurse couldn't find the doctor of that patient to say when he can leave the recovery room. The surgeon may be scrubbed up in surgery all day or elsewhere. So it was determined the anesthesiologist would be the one who would give the approval for them to leave.

So it was the same type of thing, but then you got into assignments or efficiencies, that's another matter.

MAJ Gurney: The question there being who would make assignments of personnel and who would rate those people?

BG Dunlap: It would be as if you and I are assigned to this ward and the chief nurse decided that she wanted to move you to relieve over on another ward. Someone else may come in who has never worked on that ward before, or there may be no one coming in and you are short of staff on that ward. The physician may come down there and he doesn't know the staff, and the staff doesn't know him.

It worked both ways, and he appreciated that. It was a problem that we shared. It wasn't blame on one or the other, but we both had a problem. We had all these people from all these different services. You know how it is in staffing. I've seen it as a patient. I really wonder sometimes who is going to take care of me today, particularly when we were using a functional method of assignment. Someone would come in and bring you bath water and someone else would bring a pill, a different person to do this and that.

It was an effort to have a more cohesive, controlled environment. About this time in our nursing profession, there was much controversy going on about doctors trying to run nursing. It was a very emotional topic and it carried over with some people in this program. We worked up a project, and I agreed that it would be done in certain stations because I'm not going to say no to something without

trying it. I mentioned this to you before with reference to the Physician Assistant Program. Even if I felt that it might not work, the best way to prove my point is not to just be stubborn and resist it, but to try it, and if it works, fine, we are ahead. If it doesn't work, well, then we've had a chance to prove that it won't work.

That was the way I approached it, and I have kind of done that in my administration.

MAJ Gurney: What was the official position of the ANC on this issue? You talked a little bit about the pros and cons and the fact there was a mutual need. Officially or unofficially, did the ANC feel that this was a solution? That somewhere in there was a solution along the continuum of possibilities?

BG Dunlap: There was not a favorable opinion of it among many of them because, as I said, it was very emotional. I wish Nita (Sara) Lundy were here. She was chief nurse here at BAMC. Although she had reservations about it, she really developed the concept and held them to it, working with the physicians and all the people here. It soon became evident physicians didn't want to get bogged down in things that nurses have to get involved with, staffing and so forth. The chief nurse was still making assignments, but the principle was that you just don't keep moving a nurse from one place to another without at least letting the physician in charge know they are going to be moved, that type of thing.

They soon found out we had problems. We had civilian nurses and Army Nurses. We had to have flexibility in our staffing. You got into that thing about efficiencies. As you know, at the chief nurse staff level, her efficiency is made out usually by either the deputy commander of a medical center or chief of Professional Services, or something like that. He would be the rating officer unless she outranks all of them, and then the CO has to do it. I have seen that happen, too. Then there also had to be the endorsing and reviewing officer.

So other nurses have not always rated nurses. It is ideal, but in the MEDDAC concept the line officer, the commander of the post, would perhaps be the rating officer of the hospital commander or MEDDAC commander. Then the surgeon at that Army Area would be the endorsing officer, so that there would be medical officers in the evaluation chain there. This was the same idea, that maybe the medical officer would be the rating officer, the head nurse or the supervisor the endorsing officer, and the chief nurse the reviewing officer. It was within the nursing channels, but included an evaluation by the medical officer.

That met a lot of resistance. But think in terms of the rest of the Army, and what happened with the AMEDD officers in the line or the medics assigned to line units. I used to feel so sorry for them when I saw their records come up on promotion boards because they had served as transportation officer or motor pool officer in the line. They would get crucified because they didn't pass the inspection, and they would be competing against some scientist in their same MOS. So it happens throughout the Army.

That was the basis behind why the program was attempted. I must say that some senior members of the Army Nurse Corps were very opposed to it and did

not support me. I tried to explain why we should try it. "We have a problem. Let's try it."

I went to Europe on a staff visit. After I checked in, I called back to the States to talk to the assistant chief of the Corps. She asked when I was getting back to the United States. There was a big flap about this. Some members of the Army Nurse Corps had contacted the ANA, and the ANA was having its convention in San Francisco. They wanted me to speak to the ANA about this. What was I trying to do? Sell nursing down the river? Let the physicians control nursing?

I don't think anyone who really knew me would think that I, of all people, would let physicians control nursing, but they wanted me to speak the day I got back from Europe. I was due back in Washington that day. They wanted me to fly straight on out to San Francisco instead of coming to Washington after being in Europe for several weeks. I refused to do it. I said, "First of all, I have to get back to Washington. I have to find the facts." What has gone on with the program during that period of time that's elapsed, and what were the recommendations of the people involved in the project. I wanted to discuss it with The Surgeon General before I made any public statements whatsoever. So the assistant chief of the Corps relayed that I was unable to attend because I was in Europe.

Over a period of time, the whole project withered on the vine. It was a good experience. We must talk with Nita and the people involved to get more information. We should get it documented because it was an important exercise for us.

I know some of the questions you have there relate to things I didn't get accomplished or things I regretted. I think that is at the tail end. This episode hurt me because of the lack of loyalty in our Corps. I felt that this wasn't something that some of the senior officers should have taken directly to the ANA without discussing it with me. Yet I think I proved what I was trying to do. The doctors didn't want it. They saw this after awhile. Their final attitude was, "Let them run their own service."

I can't remember the specifics of time, or the directive that went out, but General Taylor, our Surgeon General, really was trying to come up with a solution to an existing problem. The composition of the ward's staff changed, multiplied so, and all he could think about was what worked when we were at that level in a much more simple setting. Would it work? And of course, his background was R&D [Research & Development]. He had been commander of R&D before he became The Surgeon General.

He was such a wonderful person.

MAJ Gurney: This is an important issue to document because the issue and the proposed approach resurface periodically.

SPECIALTY ASSIGNMENT PILOT PROGRAM

MAJ Gurney: During your tenure as Chief, there was a pilot program for specialty assignments that were functionally directed. One was the surveillance and infection control nurse. Another was in the Facilities Planning Branch, the nurs-

es involved in facility planning. This program was initiated during your tenure. What was the rationale for this?

Infection Control Nurse

BG Dunlap: Really this all goes back again to my experience in hospital administration and experiences along the way. The infection control nurse was based on the Nurse Clinician Program. What is the expanded role of the OR nurse? The initial thinking was that infection control would be an expanded role of an OR nurse. At this time there were many studies being done on the staphylococcal infections and wound infections in the operating room. We looked at each of our clinical specialties and tried to identify an expanded or extended role appropriate for them.

So, who in the Army Nurse Corps, which MOS, had the preparation for infection control? That was all part of the operating room curriculum at that time and, as I said, consistent with the emphasis on infection control in the operating room. Our OR nurses [Colonel] Sally Travers, [Colonel] Kitty Jump, [Colonel] Alice Metzger, and [Colonel] Hazel Johnson, all of these people attended special courses because they were concerned about infections in operating rooms, staphylococcal infections. Based on their recommendations, we felt that this would be an extended role for the operating room nurse. This was implemented in different ways based on where this person could be assigned. Thinking in terms of the staff, we have preventive medicine. We have the laboratory. This person couldn't do it by herself. She had to be a part of a team that was concerned about infection, and it varied depending on the different hospitals and the resources they had.

Often she worked with the preventive medicine officer and with her specialty within the hospital doing studies. She sometimes worked with the Department of Medicine or Surgery, depending on where infections existed, whether they were wound infections, and so forth, and trying to identify the source. The laboratory officer may be involved. Then some of our Army health nurses got into that too, but primarily it was the extended role of the OR nurse. [Lieutenant Colonel] Janie Sinclair, who later became chief nurse here at Brooke, was an OR nurse and she did infection control. Lieutenant Colonel Helen Seufert was at Walter Reed doing infection control. She was an OR nurse. That was how that came about.

One of my favorite stories about infection control, and one of my pet peeves, was that old green sweater that you wear. Have I told you about that?

MAJ Gurney: You've mentioned it briefly. I think probably some of that met me when I started at Walter Reed in '73. What was the story about the green sweaters?

BG Dunlap: Our white hospital duty uniform—I don't care what color it is, but now it is white—is protective clothing. In terminology it is protective clothing. We protect ourselves in that we wear it and then we wear a clean one the next day. It protects the patient because as we come to take care of the patient we have on a

clean uniform today, then we throw it in the laundry. The quartermaster used to launder our uniforms for us. That was protective clothing. Well, here we had nurses with nice fresh white uniforms on but wearing the same green sweater day after day after day. I could not see why they had to wear a green sweater to begin with. Night people always had to have a green sweater on because they were freezing, they said. I know that, particularly on our intensive care units. Some of the units are colder. But I would say, look, if you get up and move around you wouldn't be so cold.

I hated to see them wear that green sweater day after day after day. So I asked the infection control nurse to please do a study on green sweaters to see if she could identify them as a possible source of spreading infections. I also objected to people wearing their white uniforms now that all of them lived off post. They would ride their motorcycles home or they would stop by the grocery store in that uniform. But, in theory, they were supposed to have a clean one on the next day, not wear that same uniform back.

We had talked in years past that we should have lockers for each member of the staff so that if they were living off post, they could come in their civilian clothes or other military uniform and change into their hospital uniform and therefore not take it out of the hospital. That didn't work, naturally, but these are things that were considered to address the issue of infection control. Catheters and things were not the only vehicles for transmitting infections. Personnel, their uniforms, and those green sweaters could do it too.

MAJ Gurney: What was the outcome of the green sweater study?

BG Dunlap: They didn't complete the study while I was still there. I went on in to be Chief of the Corps and their results came in after I was gone.

MAJ Gurney: They are still waiting for agar plates to grow something!

BG Dunlap: That is right. I was only out there four months. But I stirred up a few things during that time. I think you can see why I was concerned.

MAJ Gurney: Oh, I agree.

BG Dunlap: I see them working around patients in those green sweaters, and you know how you get your sleeves dirty and things splatter on you and get on you. Day after day this happens. Those sweaters could be washed supposedly. It wasn't a matter of having to dry clean them. They could be washed, but I knew some of them hadn't been washed in a long, long time.

Do we still have infection control nurses?

MAJ Gurney: Oh, yes. Oh, yes.

BG Dunlap: Is it still a nurse?

MAJ Gurney: It generally is, although there are more nurses in a lot of other fields who are getting interested in that area, but probably the majority are still coming out of the operating rooms.

BG Dunlap: I was thinking particularly of critical care units.

MAJ Gurney: There are probably not so many critical care nurses getting into that field, but the infection control nurse is definitely a partner on that critical care team. She has a role there. How effective they are is usually a matter of the individual because any time anyone is in a consultant position it is a very tenuous situation.

BG Dunlap: That is right. They can listen to you and shake their head "yes," and you walk away and they start shaking it "no."

MAJ Gurney: It is also a matter of the support that they get from the chief nurse and the head nurse.

BG Dunlap: The emphasis that they place on it.

MAJ Gurney: Yes.

BG Dunlap: I know that is true of any staff position like that. That is interesting that the role continues.

MAJ Gurney: In the smaller units it may be an additional duty for someone from the OR or quality assurance. In the larger MEDDACs, it is a full-time position, and in the MEDCENs it is a very critical position because they are very active.

BG Dunlap: Do we have any special preparation for them?

MAJ Gurney: Yes. There is a preparatory course, two to three weeks, for infection control. There is, probably once every two years, a continuing education program of a week for the infection control nurses. I think there is also an advanced course for them, plus they are eligible to participate in some of the general medical education courses in preventive medicine and other fields that the AMEDD might offer. We can't get all of them there every year, but there may be three or four [who] attend that yearly. So, yes, they do get special preparation. We also see a lot more activity in terms of preparing nurses in infection control so that they take advantage of those opportunities.

BG Dunlap: It's wonderful to see that some of the things that we consider and start, flourish. I was interested in this because it was the OR nurse, and to be the first one to do it could be kind of exciting. People like challenges. It was difficult. Any time you are the first, you are the pioneer in any field like this, to see, though, that they want to continue with it, that is good.

MAJ Gurney: We have an infection control consultant to The Surgeon General. That person has set up a system where the infection control person in each medical center becomes that region's consultant, so that every infection control nurse at every level, even the smallest MEDDAC, has someone to go to up the line for questions. That consultant is usually the infection control nurse at Walter Reed and she sets guidelines and policies and communicates them down through a network of infection control nurses.

BG Dunlap: Is she still assigned to nursing, to the chief, Department of Nursing?

MAJ Gurney: Sometimes, yes. I can't say that point-blank because I know that, at Landstuhl, that person worked in a partnership with the people in preventive medicine. But I am not sure whether the people in preventive medicine or the chief nurse rated her. In some facilities that person may be assigned to preventive medicine.

BG Dunlap: That gets into efficiencies. They need to be with someone who has the knowledge that they don't have. Perhaps someone in epidemiology, bacteriology, laboratory principles, and things like that.

Oh, you were supposed to be asking me and not me asking you.

Health Facilities Planner

MAJ Gurney: We are just doing a little role reversal. What about the health facilities planner, did that role begin during your tenure?

BG Dunlap: In my experience during the hospital administration course and experience working in hospitals like the old cantonment hospital at Fort Jackson, I saw the little individual rooms they had. The doors weren't wide enough for you to get the beds out of them when you wanted to scoot the patient down the hall on the bed because you were switching rooms or something. You couldn't get the bed out the door. Some of our hospitals were built when we had isolation wards and they failed to put hand-washing facilities in the units to allow you to wash your hands before you left the isolation unit.

Since then, and during the time I was in The Surgeon General's Office, there was quite a plan for replacement of hospitals. This was when The Surgeon General developed the plans for medical construction and planning for replacement of hospitals. First, they wanted to replace all the old cantonment hospitals. If you look around at our facilities now, like Belvoir, Knox, Benning, you can tell in which generation those hospitals were built. They all had a certain design.

In The Surgeon General's Office, we had the Health Facilities Branch. They were involved in planning the construction of those hospitals. Who knows more about what goes on in a hospital than someone in nursing? Thank goodness we had people in The Surgeon General's Office who recognized that instead of just designing hospitals without input from nursing. Edie Nuttall was assigned to Walter Reed, but yet she was also on double assignment to The Surgeon General's

Office to help plan for the new Walter Reed in the Facilities Branch. Then Lyn Wells came in full time to do that. I just felt that we needed to have a nurse assigned full time to the project team for construction of Army hospitals if we were going to get across what we needed in nursing to provide patient care and to better utilize our staff in providing the care.

Remember that we went through a period of hospital construction that created hospitals in the round. Rooms were like slices of pie with the nursing station in the center.

MAJ Gurney: I worked in one like that in Illinois. Yes, I know.

BG Dunlap: Some of us along the way used to say there is nothing like the old cantonment hospital. We had the big open ward and the nursing station. We made some changes in those old cantonment hospitals. It used to be we had a room that was the nursing station and we really couldn't see out into the ward. In some of the remodeling done before this period, back when I was still out there, we took the end room that would be the nursing station, and put glass on it so we could actually look out and observe everything going on out in the ward. At the same time, we had curtains that could be pulled at nighttime when the lights were on and we didn't want that light to go out into the ward.

But there were many things like that indicating we needed nurses in the planning stages of our hospital construction. We could not afford to wait for when the hospitals were built because then we found these things weren't compatible with patient care given by the nurses or for the efficient utilization of staff.

We would have to get another person for that new type of job. First of all, we had to get the approval of The Surgeon General and the team that is involved in facilities planning. They are responsible to The Surgeon General's Office. They have to recognize that they need a nurse and accept that. We also had to steal a nurse from another space to get the authorization.

MAJ Gurney: That was going to be my next question. Were you able to get an allocation for that or did you have to take it "out of hide?"

BG Dunlap: You robbed someone first. I shouldn't say robbing. That is negative, isn't it? But that is what we were doing.

MAJ Gurney: You were "reappropriating" your resources.

BG Dunlap: I was reallocating my resources to get someone assigned to that position. Then eventually manpower surveys followed and we got the requirement recognized to make that person a member of the team. In the hospital administration course there was a section on plant planning when it was given at the old Medical Field Service School. The project was that we took the Medical Field Service School and converted it into a 1,000-bed hospital or something similar to that. We worked together with our classmates in committees or groups to do that. When I took the

course, I worked with the group responsible for planning the psychiatric unit in that hospital. I know nothing about psychiatry, but I pretended I did. (Laughter)

So they worked together in plant planning a hospital. I don't know what they call it now in the health care administration course or if they still do it. But that was part of the course. So I felt people who were graduates of the hospital administration course had worked in that environment. Many of the MSCs were then assigned in The Surgeon General's Office. Those health facilities planners had been graduates of the Hospital Administration Program. Our nurses who were graduates of the hospital administration course and had worked as NMAs, or at least had been in that environment, they would be the best ones to assign in that particular slot. That is how we began, then, to find the people for that slot.

MAJ Gurney: Your earliest facilities planners, were they all HCA [Health Care Administration] graduates?

BG Dunlap: Lyn Wells was not. Edie Nuttall was the first one. Lyn Wells was not.

MAJ Gurney: For those that were not, where did they get their preparation for that role?

BG Dunlap: It was mostly on-the-job training if they had not been through the Health Administration Program. After we got past that first part, [Lieutenant Colonel] Gladys Rafferty was the next health facilities planner I can think of. We used Gladys in planning for Fort Campbell and Fort Polk, I think. We may have moved her out before they could finish both because they had to work on only one hospital at a time. You didn't build two hospitals at the same time. We used a project team. I think she was at Carson also. I am not sure. When that team finished the planning for that particular hospital and the construction had taken place, and then the next one would be phased in.

The Surgeon General had a tremendous five-year plan that was reviewed with the budget cycle. This would determine when we would replace this or that hospital trying to accomplish full replacement of the cantonment hospitals. Then the plan was to go into our medical centers. It would still be working beautifully today if it weren't that someone across the river known as DoD was sticking his or her nose in it trying to take over control of that.

I can remember sitting in on the budget meetings. We are going to have to push back Brooke, or we will have to push back this one or that one, or move them up a year or back a year. Instead of doing it in FY '74, we were going to have to do it in FY '75 or '76, based on something that had happened. There might be a delay in construction due to a need that had arisen at another hospital. It was done with a very systematic approach to control it. We eventually got all of our cantonment hospitals replaced, and then we began with the planned growth. We added wings because we had built a basic core that was expandable like at Belvoir, Leonard Wood, Bragg, Benning, and Knox. All of those hospitals were expanded

like that. They were expandable by adding wings onto them. We had to add an OB wing on to Fort Hood.

We needed nurses on those projects to be project officers on that team. I know Gladys Rafferty did a tremendous job. She found it really quite a challenge and exciting. I don't know if Lyn Wells is still doing it. After she retired, she continued as a consultant, I think. She was a very brilliant woman, and I think upon retirement, she had some offers in civilian life as a consultant in that area.

LEADERSHIP BY EXAMPLE

MAJ Gurney: We're going to pick up now with the last goal in that 1972 statement of goals you had for the ANC and the people in the ANC. You wanted the ANC and the people in the ANC to demonstrate leadership by example. Why was it a concern of yours? What brought this to mind as a goal?

BG Dunlap: I feel this very strongly, and I realize that I've said this often, but I feel very strongly about this. I feel strong, strong, strong!

I'm sure it's evident to you that leaders influenced my career, chief nurses and leaders I worked with. They were role models for me. I respected them as leaders, whether it was a head nurse, a chief nurse, Chief of the Corps, or supervisor, ward officer, leaders at all different levels throughout the organization.

I know how they influenced me. I have discussed the positive and negative leadership examples I saw at Fort Jackson. That negative example influenced the way I functioned thereafter. I also feel that way about positive leadership by example. I don't just give lip service to that. If I expect someone to put in a full eight-hour day of work, I put in a full eight-hour day, or longer. If I set suspense dates and expect staff papers to be back as soon as possible but not later than a suspense date, I set the example by doing that myself.

To me, those are examples of leadership. If I am genuinely concerned about the staff as individuals and as professionals, I hope that it is evident to those who I am working with and I expect that of them. I hope that the way I functioned in my career, and as Chief of the Corps, could serve as a role model to those I worked with. That's part of leadership. I am not saying I want carbon copies of me. Heaven forbid! But I think we all look at strengths and weaknesses of an individual, and sometimes we see so many weaknesses we can't see the strengths. Most of the time, though, it's the other way around, thank goodness. We see so many strengths.

I will share with you a conversation I had with the Chief of the Army Nurse Corps when she called to tell me who the next Chief of the Army Nurse Corps was going to be. She talked about all of those in consideration, the finalists, I guess, and how they were all such tremendous people. Any one would have made a good Chief of the Army Nurse Corps. Each one had his or her particular strengths, and wouldn't it be wonderful if we could pick one person who had all of those strengths.

In my opinion, we will never find a human being who has all strengths and no weaknesses, but this is what I think of in terms of leadership. As I looked at indi-

viduals, worked with individuals, I have identified certain strengths within them that I would like to be able to develop in myself. Or I have seen behaviors that I would like to demonstrate in certain situations. When I was in the senior role, because of the position it put me in, "I'm the leader." I hope that those who worked with me have seen more than just position or title in my relationship with them. I hope that they have been able to identify some of my strengths in the way I functioned in that role, and as a person, and that they could try to develop or apply those traits in their own future careers in establishing and meeting their own goals.

I hope that that is true throughout the Army Nurse Corps, at all levels. You have served with chief nurses who you felt were tremendous. "What a tremendous chief nurse," and you hoped that when you became chief nurse, you would be able to do this or that like she did. Perhaps it was the relationship she had with the commanding officer of her hospital. You hoped that when you were a chief nurse, you could have that kind of relationship with your commanding officer, one of mutual respect and appreciation of each other's job.

You have also served with chief nurses, or in other staff positions, where you observed chief nurses, where you thought, "Gosh, wouldn't it have been wonderful if she could have done this or that in a relationship. I hope that if I were in her position, I'd be able to do this or that." That's all part of leadership. The individuals who work with you recognize the strengths and the weaknesses and appreciate what you are trying to do in your situation.

In retirement, I have said over and over that the people who followed me as Chief are each doing the best they can in their particular situation. They are dealing with those circumstances, the people, and the needs of that time as far as the Army Nurse Corps and the AMEDD is concerned. Certainly, none of the three who have been Chief since I was Chief are alike. We are all individuals, and we all approach things in our own way. But I think you might find common characteristics among leaders if you look at the Chiefs of the Corps you've known. There are some things in common. We each approached the role differently, but there is bound to be something in common that enabled us to be selected to be Chief of the Corps. What is it? You as a staff officer have been in a position to see this. What have you—I'm not asking you for an answer; you're not going to flunk this exam.

MAJ Gurney: Thank you, ma'am. (Laughter)

BG Dunlap: When did you come in?

MAJ Gurney: '73.

BG Dunlap: '73. Okay. So, you've known our Chief at the time, and you've known General Parks and General Johnson and now General Slewitzke. As you've looked at these Chiefs, I'm sure you looked at each one of us and examined the strengths and weaknesses of each of us. You recognized the things that you hoped you could develop, or not develop, in your career. That's what I talk

about, leadership. It isn't that I'm the leader, come on, follow me down the ten flights of steps. If you start down the ten flights of steps, the next thing you know, you've got a whole bunch of people coming behind you. Here I am saying, "You better slow down. I've got bifocals. I've got to see where I'm stepping next, or go around me." I'm kidding about that now. It was my experience yesterday. [BG Dunlap was referring to her experience the previous day. She was on the 10th floor of an office building at the meeting of a company where she sits on the Board of Directors when the fire alarm sounded. She led the parade down ten flights of stairs to sanctuary outside the building!] That doesn't just happen in the Army Nurse Corps; it's just a part of your core philosophy, your character that develops and the way you do things. I do things for people because I respect them and admire them.

Colonel Short, I loved. I go out to her barbecue for the Hollywood Park Firemen benefit every year. This year I couldn't eat any of it except the carbohydrate, which was the beans. I put the lid on the rest of the food, and brought it home to Carolyn to eat. I wouldn't think of not going—that's the big event she has every year. She buys tickets for all of us to go out there. That's leadership. My respect for her as an individual developed because of the leadership she demonstrated as my chief nurse when I was a lieutenant, or when I was a young, stupid captain. You can think of people in your career the same way.

I felt in the Army Nurse Corps that I wanted those of us who were in leadership positions, by title of position, to be aware of the impact we could have on those within our command supervision. We should be aware of it, because some out there were not. In each of our experiences, do we look the role of the chief nurse? Do we act the role of the chief nurse, not only cosmetically, but also in our actions with others? How do we make rounds of a hospital? Do people do things for us because we are the chief? Or are they doing it because they want to do it? I'm talking now at all levels, not just at the level of the Chief of the Corps. Do they want to do it? If they really want to do it, then that individual is a leader. I felt we had to be sensitive to that and the impact we can have on an individual's life. It could be good or bad. Hopefully, good.

MAJ Gurney: Wonderful, that is a very good articulation of that.

BG Dunlap: Now, we can move to the next card.

MAJ Gurney: Yes, ma'am!

NURSING RESEARCH

What was the nursing research program in the Army Nurse Corps at the time? Some of the literature that I looked at described the move to cut down the research program, to move it, to do whatever they could to cut costs.

BG Dunlap: Money, money, money, money, money.

MAJ Gurney: It drives the beast.

BG Dunlap: That's right.

Nursing Consultant in Research and Development Command

Money, money, money, money. At that time we still had nurses assigned to WRAIR [Walter Reed Army Institute of Research]. There were some fine people out there. But, in their opinion, they were really not doing nursing research. They were not given the support to do nursing research as they wanted to do it. Others wanted to cut some of those spaces.

MAJ Gurney: Whose opinion? The nurses themselves felt they weren't given the support to do the nursing research they wanted to do? Okay. But someone else wanted to cut the spaces?

BG Dunlap: Also, we had nurses assigned at Walter Reed to the research unit that came under WRAIR.

MAJ Gurney: The Kyle Metabolic Unit?

BG Dunlap: Yes, and we also had, we didn't have the "Nut Lab" then, did we? It was the "Nutrition Lab" out at Fitzsimons. I can't remember just exactly if we still had that out there or not. We had it when I did my residency at Fitzsimons. I used to work there. We had it out at Letterman. Then, of course, there was the burn unit. Hazel Johnson was assigned to R&D [Research and Development] Command. I wanted her assigned as the nurse consultant for R&D. She was really assigned in a special project group within R&D, but I wanted her to be the nurse consultant for R&D and to then have a relationship with all of the nurses assigned to the different R&D research units, such as down at the burn unit. This would enable the nurses assigned to the burn unit to have a nursing chain of command in R&D. At that point, they didn't have that.

MAJ Gurney: A nursing chain of command simply in terms of relationships? Or in authority?

BG Dunlap: Not authority. But the nurses assigned to the burn unit had no nurse within R&D to relate to. The chief nurse at BAMC, there's a relationship, but not an R&D relationship. No, it's a nurse-to-nurse relationship, but not really within the command structure. Over that, you have The Surgeon General's Office, but it's really not in the R&D command structure. At first General [Richard] Taylor was over there and then he became Surgeon General. [Brigadier General] Gary Ratin later became commander of R&D and has just retired. He was deputy at R & D at that time. We had long talks about that. He agreed with my goal to have Hazel assigned in a position as a nurse consultant for R&D.

We never were really able to get the authorization approved. But I think that some guidance did go out from R&D to the nurses at these different units to feel

free to contact her if they wanted to discuss something. She in turn could contact him to discuss nursing matters. I felt that they had to have some kind of nursing R&D contact. We threw them to the wolves out there, really, when we assigned them to places like that. That was really my push in R&D, to get the organizational changes to place Hazel as a nurse consultant in R&D and to get her used in that capacity by the commander of R&D.

Walter Reed Army Institute of Research (WRAIR)

As far as out at WRAIR, I had mixed feelings about that. We needed nurses, yes. I didn't want to eliminate them at all. Should they be concentrating solely on nursing research? Or should they also be involved in projects that WRAIR had ongoing that nurses could be involved in? It's a team concept, and the issue had a lot to do with the individuals assigned and the preparation of the individuals assigned, as to whether they should be involved in total AMEDD studies.

The Institute of Surgical Research

I have been so disappointed in nursing involvement in research in the burn unit. This goes way back to when I was in the Branch even. We weren't really getting nursing research out of the burn unit. They provided tremendous nursing care, but nursing research that could then be documented and made available for the nursing care of burn patients wasn't there. We tried. Finally, when we got some nurses prepared at the Ph.D. level, we could finally assign someone there for research. Poor Dottie Berry died prematurely. I don't know what's coming out of there now, but to my knowledge, you're not getting nursing research out of there. I read in all of these journals about burn units or burn centers and nursing care there. I don't see anything written about our nurses assigned to the burn unit. I am not being critical of the ones there now, but this has been true over a long period of time. I know at one time, like when [Lieutenant Colonel] Nellie Henley and [Major] Jo Krumanocker were assigned there and when Colonel Artz was there, they went out and they gave speeches. They weren't prepared to do nursing research. They were tremendous nurse clinicians, you know, well prepared in the clinical aspects of burn care. That's been a disappointment to us.

MAJ Gurney: We're hoping to turn that around. We found out that if we don't title it nursing research, but if we call it "clinical investigation," that it's much more acceptable to the physician administrators. There are several active protocols down there right now.

BG Dunlap: In the burn unit?

MAJ Gurney: Yes.

BG Dunlap: We can't keep chief nurses in there.

MAJ Gurney: Well, we've had a chief there now, Lieutenant Colonel Donna Kaiser, who's been there almost four years.

Division of Nursing, WRAIR

MAJ Gurney: What about the attempts to either decrease or eliminate authorizations or allocations for the nursing research at Walter Reed? What was the outcome for the Nursing Division at WRAIR?

BG Dunlap: We still had a nursing division at WRAIR when I left, when I retired.

MAJ Gurney: Were you able to maintain the allocations that you wanted there, or did you change the focus?

BG Dunlap: How is it now that Ollie North says—no, he wasn't the one—"To the best of my recollection . . ."?

MAJ Gurney: Yes. (Laughter)

BG Dunlap: To the best of my recollection, we still had the same number of spaces there. It was an issue still in limbo. That's why I felt that if we had Hazel as a nurse consultant, she could be dealing through Research Command channels with these things. They have to deal with the question, what does R&D want out of nursing in these different places where they have it?

HEALTH SERVICES COMMAND

MAJ Gurney: If we could move on. Can we talk now about the development of Health Services Command? That occurred while you were Chief in 1973. What was the motivation for that?

BG Dunlap: To get people out of Washington. (Laughter)

No. Really. They said that there are too many military in Washington. People come visit the capital and see all these military. That's why we didn't wear uniforms, you know. So many people come from other countries to visit our nation's capital and all they see is an armed fortress up there. They wanted to decentralize and get people out of Washington. So they took a look-see at the organization and its span of control and came up with the recommendation that we establish a separate command outside of the beltway. The Surgeon General was responsible for everything worldwide. Now, the recent study wanted to put it back, didn't it? That one's been put on the shelf, from what I understand. But at that time a study was done. It was presented to The Surgeon General's staff at a staff meeting. That was the first time we got a look at it to see who would be down at Health Services Command. When I got a look at it, I couldn't believe it. They had the professional people coming under DCSPER [Deputy Chief of Staff, Personnel].

We were asked to take it home over the weekend and look at it and come back with our recommendations on Monday. Now, this instruction was to his staff. Some of them had been involved in some of it, but others hadn't. The rec-

ommendation that I made was that we have a deputy chief of staff for Professional Services. I really wanted something like we had for the Dental Corps. At that time we had a deputy surgeon, the commander, I guess, was Dental Corps. I felt that we should have an assistant or a deputy chief for Nursing. Going back to the way you operate, you don't want to lose entirely and end up having the professional people down under personnel. I thought, well, if we have a deputy chief of staff for Professional Services, at least the professional personnel would be on an organizational level in the chain of command. The chain would go to the Deputy Chief of Staff and then on up, as opposed to having them under DCSPER and then having probably nursing and Medical Corps just there as a personnel function.

That was my recommendation. After much discussion, The Surgeon General bought off on this when it was presented. In the organization we'd have a deputy chief of staff of Professional [Services] and under professional we'd have nursing and MSCs and all the professionals in the organization. It was decided that our deputy surgeon general was going to come down as the commander of Health Services Command and [Major] General [Spurgeon] Neel served in that position. Then the question was, who would we send as chief nurse of Health Services Command? I knew it was not going to be an easy job. It was going to be a hard job, and it was going to take someone who was a fighter. What is it we say on our efficiencies, "Courage of her convictions"?

MAJ Gurney: That's right.

BG Dunlap: It took someone who was knowledgeable and a good staff officer, respected by the Army Nurse Corps because the chief nurses would come to her. It would require establishing relationships. Organizational relationships were going to be very difficult, and it had to be someone that I certainly had great respect for. There had to be great loyalty between the two of us for we would depend on each other. I would support her and she was going to be loyal to me and she would keep me informed. We did keep each other informed in the organization through informal channels plus formal channels. Ginnie [Virginia] Brown was selected. She was one of the best choices I ever made.

It was one of the hardest decisions I ever had to make because I had to give up the position of assistant to the Chief, Army Nurse Corps. [Lieutenant Colonel] Betty Labbe was in that position. We had established that position, and Nita Lundy was the first assistant to the Chief, Army Nurse Corps. Anna Mae Hays and then Sue Frazier served in that position.

MAJ Gurney: You're talking about the administrative position—

BG Dunlap: Not the assistant chief, but the assistant to the Chief of the Army Nurse Corps.

MAJ Gurney: That was a nurse in an administrative staff position in that office.

BG Dunlap: Yes, the first was [Lieutenant Colonel] Nita Lundy, who was assistant to the Chief of the Army Nurse Corps. Then Sue Frazier was the assistant to Anna Mae and for a while when I went in. She went to the War College. I brought in Betty Labbe, who had finished Command and General Staff College. I gave up that position, and she came down to be the assistant to Ginnie Brown at Health Services Command. That was rough. Later then, you know, they now have an MSC in that office.

MAJ Gurney: Could we go back then to the discussion establishing the Health Services Command? Were there any nurses involved in the early coordination of this program, before it was presented at the staff meeting as a concept?

BG Dunlap: I was not.

MAJ Gurney: Were there any nurses on the committee or whatever group was doing that?

BG Dunlap: No. Unless it was done down in Special Projects. We had a nurse assigned down in Special Projects.

MAJ Gurney: Was that out of The Surgeon General's Office?

BG Dunlap: Yes. But a lot of us on the staff were not aware of what the big plan was until it was shown to us.

MAJ Gurney: Were you given alternatives, or was it simply that you were given the concept of having a subordinate commander, a command for health facilities outside of the Washington area?

BG Dunlap: We were given a copy of the organizational structure of what HSC would be like, and that's what we were to comment on for our input at that level. Based on our comments and recommendations, the final plan then was developed.

MAJ Gurney: Did this organization then change the relationships within the medical facilities in CONUS? I am thinking in comparison to the regional kind of concept that they had when they were under "Armies." When it changed to Health Services Command did that change that structure?

BG Dunlap: According to the formal structure, the chief nurses of all the hospitals would report to Ginnie Brown as chief nurse of HSC. The chief nurse of HSC had responsibility for nursing and nursing service in the hospitals under HSC. At that time, that did not include Hawaii and the overseas areas.

MAJ Gurney: Was this an authority relationship, or was it simply a "consultant" kind of relationship? I am trying to think of the concept. Was it a straight line or a

dotted line kind of thing? The HSC chief nurse didn't have command and control over these chief nurses; they were still subordinated to their commanders, correct?

BG Dunlap: That's right. Take for instance, the commander at Fort Hood. He was responsible to HSC. Well, the chief nurse at Fort Hood was responsible as far as nursing was concerned. The next nurse in the chain of command would be the chief nurse of HSC.

We still controlled staffing out of The Surgeon General's Office. We still made selections for long-term civilian training and so forth. But there was a relationship with the chief nurse of HSC. Personnel actions were supposed to come through HSC. Requests for schooling and everything else would have to come through HSC supposedly, and then on up to The Surgeon General's Office. I guess if you wanted to look at the formal relationship, we would have had to go through the chief nurse of HSC to go talk to a chief nurse of a hospital. Well, we didn't do it that way actually. It depends on when we selected the chief nurse, because one of the hardest things was to get the chief nurses of the hospitals to go through Ginnie Brown instead of calling me directly or calling The Surgeon General's Office directly. We'd have to say, "Have you discussed this with Colonel Brown?"

MAJ Gurney: You were talking about how difficult it was to change people's communications patterns.

BG Dunlap: That's right. It's because we had worked in the other formal and informal channels. I knew these chief nurses. They knew me and they knew Edie Nuttall or whoever was in the Assignment Branch. We knew them and we had worked with them that way, and we knew them personally. We might have a chief nurse, Colonel Nita Lundy, down here at BAMC. Nita and I have known each other for a long, long time. I was an instructor in hospital administration when she was going through there. We had a personal relationship in addition to a professional relationship. It was very easy for her to pick up a phone to "call Lil," to ask me about something or tell me something. It's hard to break those patterns, as you say.

MAJ Gurney: How else did the reorganization affect your role as Chief of the Army Nurse Corps?

BG Dunlap: As long as assignments were still in The Surgeon General's Office, that's the control point, personnel. As Chief of the Army Nurse Corps, I had to be aware of what was going on at HSC, and the chief nurse at HSC kept me informed very nicely about papers that might be coming forward to The Surgeon General's Office. I knew then that it was in the wind, just in case I didn't get a chop on it, and in case she hadn't had a chop on it down there. I knew what her position was, that that position was contrary to the one coming forward, and I knew this through informal channels.

I can remember going to a section where they had put the letters—what's that system that they had where you could put a letter on a machine up there, a tele-type thing, and it comes off down here?

MAJ Gurney: Kind of a facsimile type thing?

BG Dunlap: Or it could work the other way around getting information to her or from her to me, so I'd know what to expect and she'd know what to expect. That was the informal channel that might be frowned on, but we had to work that way.

How else did it affect me? There was always the question about whether we needed the consultants in the different specialties. This was not just the Army Nurse Corps—The Surgeon General also had consultants in the different clinical specialties. HSC had a nurse consultant. We didn't have them in all the clinical specialties. Was that duplication? What would be the role of the consultants at HSC and in The Surgeon General's Office? At HSC we had the nurse assigned to the IG team and to manpower, and this was good. If I hadn't been able to get those people in those positions, the Army Nurse Corps would have had a rough time. At the HSC level, Ginnie Brown had to be able to work closely with those people.

MAJ Gurney: Was it difficult for you to get those folks in there? Was that a battle?

BG Dunlap: We had to fight for spaces every time. "Why do you need nurse spaces?" But fortunately, one of the officers who was the IG officer had been the IG up in The Surgeon General's Office and had been a student of mine when I was teaching in hospital admin. When we started having a nurse assigned to go with him on the IG inspections out of The Surgeon General's Office, he appreciated and wanted a nurse on the IG team. So, we had a nurse on the IG team down there. We really worked hard in establishing and trying to work within the formal organizational structure, but recognized that we had to work in an informal structure also, to be kept fully informed.

Enlisted personnel was one big area of concern. Remember, the commander of AMEDD PERSA really believed that the Chief of the Army Nurse Corps had nothing to do with enlisted personnel. I'll give you an example. I gave a briefing to the AMEDD PERSA chief and to The Surgeon General about the 91 Charlies. We were overstrength in 91Cs, but yet I had been hearing from all the chief nurses of HSC about the shortage of 91Cs, and I saw it when I made staff visits. I'd get on the phone and call the chief nurse of HSC and ask her to give me a readout on how many 91 Charlies nursing service was authorized and how many were assigned to nursing service. I could then present it at The Surgeon General's general staff conference.

If you look at the number authorized and the number assigned to the hospitals, we may be overstrength in 91 Charlies on the hospital books, but how many of them authorized for nursing service were really assigned to nursing service? Everybody wanted our fine 91 Charlies assigned to him or her, outside of nursing

service. When AMEDD PERSA's commander says, "We're overstrength in 91 Charlies. We can cut down on training 91Cs or we can reclassify 91 Charlies," I can say, "Nursing service is short 91 Charlies at Fort Hood by X number," and I could give the statistics.

This used to be a battle royal. At The Surgeon General's staff meeting they would look forward to seeing what I was going to be fighting with AMEDD PERSA's chief about. Thank goodness I had a tremendous chief nurse down at HSC who responded to any request that I made to keep me informed and to help me make the proper decisions, or better decisions and recommendations about what we should do. That was Ginnie Brown.

So, those are just some of the things. I don't know what happens now, probably the same thing.

MAJ Gurney: The whole command and control study was tabled because it attempted to place command of health services back under The Surgeon General. But it came down to the basic issue you encountered; they couldn't put the people back in Washington. The restrictions on the number of personnel in the Washington, D.C., area were prohibitive. That just canned the whole thing.

BG Dunlap: So, what precipitated moving us down here is what's kept it down here.

MAJ Gurney: Was there some dissent to the reorganization? Were there some people who really didn't want to do this?

BG Dunlap: Yes.

MAJ Gurney: Why did they dissent?

BG Dunlap: Well, each one had his or her own individual reasons. They anticipated problems. They were saying The Surgeon General, by law, is responsible for all of health services. He reports to the Army Chief of Staff. The commander of HSC reports to the Chief of Staff also. He has a command, just like any other major commander. So really, you're putting The Surgeon General in a strictly staff position, and in theory, the commander of HSC, by reporting to the DA level, not The Surgeon General, could respond differently than what The Surgeon General wanted.

I've mentioned it before, but the hardest thing is to define and put into operation the organizational relationships, to formalize them. It takes time to do it, and it requires the people to do it. I think I've mentioned, when I was in the chief of the Assignment Branch, one morning, bright and early, I got a long distance call from Japan. It was a young male lieutenant nurse over there calling me from Japan wanting to talk to me about his assignment because he didn't want to go to a certain place. I almost dropped my teeth. I'd never think of doing that, calling the chief of Branch, you know.

I asked if he had discussed it with his chief nurse there at the hospital. "Well, no." Instead he just called Washington directly. Confusing chain of command wasn't a problem confined to the HSC situation. It had existed before, when we went through Army Areas and overseas commands and things like that. But since it was right here in the United States and it involved all of the hospitals in the United States, it was more difficult. There was the issue of duplication of consultants and other staff positions. We didn't want to duplicate because we didn't have enough nurses and money and time to duplicate. The chief nurse of Health Services Command had to make visits to the hospitals if she wanted to know what was going on at those hospitals as far as nursing was concerned. She had to establish a relationship between the chief nurse of the hospital and herself, so they felt comfortable in their relationship.

I, as Chief of the Army Nurse Corps, had to visit the hospitals to be able to serve as the staff officer to The Surgeon General about what was going on. They expect you to come out and visit, and it's a highlight—highlight or a dim light. (Laughter)

BG Dunlap: It was always a major event for a visit from The Surgeon General's Office, naturally, no matter which Corps Chief it might be. It's important to the Chief of the Corps not only for the establishment of the relationships there, but for supporting the chief nurses out there in nursing service. As I went to visit a hospital and have an entrance visit with the chief nurse, I was out there to try to help identify any problems she might have so that I could be able to discuss them with the commander, to support my chief nurse there.

By the same token, there might be some things I wanted done that I wanted to be sure that the chief nurse understood so that she could be the standard bearer. I discussed it with the commander of the hospital, and perhaps the commander of the post, to explain where I was coming from. Once you got that general officer status, you have entrance and exit interviews at the post level. During those you could support the chief nurse and the hospital commander at the post level.

But because you don't want the poor people down at the hospital being bombarded with staff visits, those things had to be worked out. It wasn't hard, as long as you had people like Ginnie Brown or Marge Wilson when she was in there. Marge was not there when I was Chief of the Corps. Marge was chief nurse at Walter Reed, and then she went to Europe. She was chief nurse in Europe when I made my staff visits over there.

We can tell you stories about those visits, too. (Laughter)

Vietnam

MAJ Gurney: During your tenure as Chief of the Army Nurse Corps, in the 1973 to 1975 time period, the activities in Vietnam were winding down and they were beginning to bring troops back. But the 1972 era was a very active period. What were the activities of the Corps in Vietnam, and how did they affect the Office of the Chief of the Army Nurse Corps?

BG Dunlap: During my term as Chief—understand, my relationship with Vietnam goes back before that to my time as chief nurse in Okinawa. There we took care of the patients and were concerned about that. Later, in the Assignment Branch, I was responsible for keeping 900 nurses over there all the time.

MAJ Gurney: Well, go ahead and discuss it in that context. That's fine.

BG Dunlap: In Okinawa, as chief nurse over there, we received patients who were evacuated out of Vietnam into our hospital in Okinawa. Some were hospitalized there, rehabilitated, and returned to duty. Others were evacuated up to Japan or back to the States.

When I was chief of the Assignment Branch, that was '66 to '68, my responsibilities then were to see to it that we had the required number of Army Nurses over in Vietnam, with the right distribution of MOS's. The top strength was 900 at one time. That was just like turning the fruit basket upside down or something, whatever they called it, as far as staffing hospitals, because our Army Nurses were volunteers. There were very few Army Nurses who went to Vietnam that were made to go. Those were primarily in high demand MOS's like OR and anesthesia. They were volunteers to begin with. But as it went on, it changed some. We had trouble. Some MOS's wanted to go, and we didn't have TDA [Table of Distribution and Allowances] positions for them over there, i.e., Army health nursing and areas like that. But they wanted to go.

When I was out at First Army, we were getting patients back from Vietnam. As I'd visit our different hospitals, we'd see them there. We'd see the staffing of our hospitals and the special care that they needed; certainly this was true at Walter Reed, where we had a number of Vietnam returnees as patients.

When I went in as Chief of the Army Nurse Corps, I had been concerned about patient care of the Vietnam casualties overseas, stateside, and the staffing of our hospitals to provide care for them. My responsibility didn't change. Even as Chief of the Corps, I still had that same responsibility. It was just further removed from where the actual care was given. We had congressionals that we had to respond to. They were about going overseas. This might be of interest in that sometimes we had a married nurse scheduled to go overseas, and her husband didn't want her to go. I can remember two cases where the husband came in to us, one to the Assignment Branch and one to my office, to talk to me about it to see if we couldn't take his wife off orders. Well, we never did anything like that. We talked to the wife, not to the husband who didn't want her to go. The wives wanted to go. So they went.

We had congressionals from people who were in Vietnam and received orders to come back to the States upon completion of their tour, and they weren't always happy with where they were being reassigned back in the States. They had been serving together in hospitals in Vietnam, and they wanted to come back to the States together, go to the same hospital, but we couldn't always do that because we had to fill our spaces here according to needs in particular MOS's.

We got congressionals because they wrote to their congressman and couldn't understand why Jane could go to a medical center and I had to go to Fort Polk or

some place like that. Why can't I go to the medical center too? But on the whole, I felt that the Army Nurse Corps had as little turbulence and discontent as one could expect, under the circumstances. I know when I was in the Assignment Branch, [Lieutenant] General [Leonard] Heaton, The Surgeon General at the time, made a trip to Vietnam. When he came back, he complimented the Army Nurse Corps and the chief nurse who had been sent over there, because the Army Nurse Corps tried to send their best-qualified people. We sent officers who had been chief nurses or could be chief nurses, whereas some of the other Corps did not. General Heaton had made the statement that the Army Nurse Corps really provided the stability for care that was being given over there because of the experience and the dedication of the Army Nurse Corps. I think that was true throughout. As a result of his comments, I know some of the other Corps reexamined who they assigned over there.

When the chief nurses returned from Vietnam, we had them come into The Surgeon General's Office, specifically those who had served as the chief nurse of Vietnam, not each individual hospital's chief nurse. We had them come in for lessons learned discussions.

MAJ Gurney: What was this process?

BG Dunlap: We gave them a chance to get their thoughts together and prepare a briefing, and then we would have members of the Army Nurse Corps in The Surgeon General's Office come in for a briefing. We would invite other Corps to The Surgeon General's Office to attend. The Surgeon General did this for commanders who were over there because we truly were trying to find out, to get their recommendations and try to not repeat mistakes that we maybe had made, not only in Vietnam but for the future.

Our chief nurses gave some really fine interviews. I can remember we read about or heard about a unit sent up north. Because it was a combat area, they sent all male nurses. That didn't work. That was one example.

MAJ Gurney: Why didn't it work?

BG Dunlap: Those who were there felt that in their judgment, it was best to have a mixture of male and female. Each sex brings a certain something to the patient. You've heard it said over and over in every war that—I remember some commanders—was it General Eisenhower or Bradley or one of them? They wanted to be sure the nurses were up as far forward with the hospitals as they could be because when the young GI woke up in the hospital and there was a female nurse up there, there was a certain amount of comfort and security they felt. Who was it—Frances Singer?

MAJ Gurney: Frances Slanger in Normandy.

BG Dunlap: She wrote about this.

MAJ Gurney: She wrote a letter to the editor of *Stars and Stripes*.

BG Dunlap: She had written about the nurses over there, and a GI wrote, "You know, you don't have to be here, but we do."

MAJ Gurney: That was it.

BG Dunlap: You know which one I'm talking about. I saw it in World War II. We were in the jungles. We were eating the same rations—not like the men in fox-holes, but we were living under the same conditions and eating the same C-rations and stuff like that. They didn't expect a woman to have to do it, and when a woman did it and volunteered to do it, it meant something to them.

MAJ Gurney: You think that unit in the north of Vietnam, that unit of men lacked that?

BG Dunlap: I don't know. I'm trying to think if Ski Straley was chief nurse over there then or not, whether it was Ski, or Jennie Caylor, or Pat Murphy, or Althea Williams, or Nellie Henley. They were chief nurses in Vietnam. They would be able to talk more about that. But that was how it was reported back to us.

UNIFORMS FOR VIETNAM

Uniforms were always a problem, always a problem!

MAJ Gurney: Uniforms for the nurses overseas in Vietnam?

BG Dunlap: Getting them into uniforms before they went over there. What are they going to wear? What we had in stock here wasn't what they needed over there. You've seen the uniforms they worked in, in Vietnam. Just like in World War II, when we went over. Finally, they shipped us those brown-and-white-striped seersuckers. Well, mosquitos could eat through those things and eat us too. It's always been a problem to get the proper uniform and the proper sizes and at the right time in our overseas areas. So, we had problems.

In Saigon, they were wearing their whites, regular hospital uniforms. In some forward areas they were wearing a field uniform. You've seen pictures. You know all about the field uniforms.

MAJ Gurney: It was a tropical-wear field uniform, wasn't that essentially that they ended up with?

BG Dunlap: But the boots, you never can get boots to fit the women. We worked on the development of the uniforms. You've seen the uniforms with the pockets on the sleeves where the scissors would fit into them. There were pockets and things like that. They were constantly trying to work on the development of the uniform

for them. What we didn't develop and send over, they had made when they got over there.

MAJ Gurney: Was there anything in any strategy in particular that helped to deal with that issue, any system or any way of solving that?

BG Dunlap: We had to go through the Army system or Navy Quartermaster. Anything that goes through the Navy takes forever to develop. At that time, they still had some of the people who had been there in World War I, I think. You couldn't convince them they didn't need drop-seat fatigue pants. You remember those, don't you? The green ones we wore that buttoned up the side?

MAJ Gurney: Oh yes, I do!

BG Dunlap: That's what I call the drop-seat fatigue. We couldn't convince them that women didn't wear things like that in civilian life. You wear slacks that might be fastened on the side or zip up the front. They still wanted the drop-seat fatigues so that we could straddle slit trenches. (Laughter)

I'm serious!

MAJ Gurney: I never thought of that. I never knew the reason for that design.

BG Dunlap: That's why they had them.

REPLACEMENT SYSTEM FOR VIETNAM

MAJ Gurney: Tell me about the replacement system in Vietnam. You alluded to that when we talked about Assignment Branch. Can you discuss the difficulty with one-year individual replacements as opposed to unit-level replacements?

BG Dunlap: We were recruiting. I know I discussed it because I was talking about setting up a program recruiting people with guaranteed assignments to Vietnam. The tour was one year. They signed up for two years. They'd come through our orientation here, and then once we'd set up the program where they would stay a few months at a stateside assignment and then go to Vietnam, it was time for them to get out by the time they came back. A lot of them extended, not in Vietnam, but extended and stayed on active duty. But many of them got out. They had fulfilled their commitment and that was it, they got out. Some of them came back in after that when they realized what it had done to them as far as the experience and the esprit de corps that they had developed and how they missed being in the military.

SUBSTANCE ABUSE

One area that was of concern to me was substance abuse. I knew that we had some Army Nurses who drank too much, not just over there. I have never known,

and it was never brought to my attention, nor did I ever find any nurse who was on drugs. That doesn't mean that they weren't there. But our policy was that if we have a nurse who was a substance abuser, if he or she made it known and sought help, help was made available to them. If they stick with it, they can stay in the Army Nurse Corps. But if they don't make it known, don't seek help, and we find it out and offer help and they decline, they're out. If they seek help and are not able to stick with it, they're out. In my opinion, we just had no place in the Army Nurse Corps for the alcoholic or the drug user.

I asked every chief nurse of Vietnam when they came back in their debriefings, and privately when we were talking, about drugs. We kept hearing about drugs. We didn't see it in The Surgeon General's reports that much, but in the media. To listen to them you'd think everybody over there was on some kind of dope. Not a single one of those chief nurses reported to me any drug abuse of Army Nurses. I feel they would have if it was there. When people asked if nurses used drugs, I could say, "Not to my knowledge," with all honesty.

I don't think nurses are lily white or all angels. I'm sure some of them drank. But if any of them were alcoholics, it was made known to me by the chief nurses because they knew how I felt about it. I talked about it at every station, every staff visit I made. When the chief nurse gets up and gives that song and dance, I would always talk about substance abuse and just say what I told you. So, they knew where I stood.

I was trying to think of anything else in particular about Vietnam.

PREGNANCY ON ACTIVE DUTY

MAJ Gurney: What about the issue of women who became pregnant while overseas in Vietnam?

BG Dunlap: Now you're going to think I've been out in the sun too long. But I was trying to think, after reviewing that, of anyone who did. I think that I know some of them did. They're bound to. But I cannot think of what we did for women in the service who became pregnant. Originally, if they became pregnant, they had to request to remain on active duty.

MAJ Gurney: The first rule was that if they became pregnant they had to get out.

BG Dunlap: That's right. And then the policy became that when you became pregnant, you could request to remain on active duty.

We in the Army Nurse Corps Assignment Branch reviewed those requests and their records very closely. There was no blanket approval. The position we took was that if the individual demonstrated the ability to manage her affairs after the baby was born, and we felt that she could manage this situation, we granted permission, with the understanding that if it interfered with her duty, she would have to ask to be relieved.

I can think of one case in particular. I won't give you her name. But there was no doubt in our mind that she could manage it, just because of the way she had

performed throughout her career. She did manage it and she had two babies. I don't know if she had a third one or not. But she continued to serve in a field situation and then in a hospital situation and in some other special assignments.

But if we felt that this other person was an individual who probably wouldn't be able to cope with that, we didn't grant her permission to stay in. We also asked our chief nurses to let us know if any of those who were granted waivers and permission to stay on active duty, if they had absences. They weren't to be given any special consideration in terms of not going out on field exercises or not doing this or that. They had to pull their share of the workload. If there were some who could not, or would not, then they were to reflect that in their efficiencies and counsel them about going ahead and resigning. We weren't about to have those without children doing all the work because the ones with children couldn't meet their responsibilities as an Army Nurse Corps officer. That was our approach to it then.

About this time, all that equal rights stuff flared up, and we were directed by DoD that we could not use this as a way to eliminate people from the service. We had efficiencies, and if we wanted to eliminate them for substandard performance, we could do that through the efficiency reports, but we could not use their family demands as reason for elimination. I must admit that it was only those who we felt, based on a history of substandard performance, couldn't cope with still another stress, that we refused their request for retention. Everybody who was eliminated had demonstrated substandard performance. We didn't get anyone out except through the efficiency system. If these individuals hadn't been pregnant, they eventually would have probably gone that way too.

In any case, ultimately we were directed that we no longer could grant waivers, that everybody who was pregnant could remain on active duty and didn't even have to request to remain on active duty. If they didn't want to, they didn't have to. But if they wanted to, they could remain on active duty.

That brought us then to maternity leave. How should we handle the pregnant nurse who has morning sickness? Some will go through all of the trials and tribulations of pregnancy, work 3:00 to 11:00, and go off duty at 11 PM and admit herself to the hospital and have the baby at 1 AM. Then there will be the one who is always sick or talking to the ward officer about her morning sickness and she's put on quarters, not admitted to the hospital, but put on quarters for a day or up to three days at a time. This could go on throughout the pregnancy.

Then they go into the hospital and have the baby, and then they have to be off. This predated the development of Army policy for this. Do they have to take annual leave? Was it sick leave? It wasn't considered sick leave. They'd have to take annual leave to be off afterwards. My position was that pregnancy was a medical condition, and the officer would work, depending on her medical condition and the advice of her physician. If he said she could work up to the time of her delivery and wanted to, let her do it. But if at some point in the pregnancy he said it would endanger her life or the baby's life, well, then she should be hospitalized and the pregnancy treated as a medical condition.

I said, "How about all these people, these men who are in the hospital for certain conditions and then get convalescent leave. Why can't this maternity leave be

a convalescent type leave following the medical condition?" That was my position. The length of it was dependent on the physician.

We had more or less uniform policies in the federal government for Civil Service employees. For them, they were allowed six weeks' post-partum before they needed to come back. But we had Army Nurses who didn't want to stay out that long. We had others who wanted to stay out longer. But we tried to establish the policy to be flexible enough that the individual and the physician could determine when she should go off duty and when she should come back on duty, treating it as a medical condition.

Not everybody agreed with it, but that's the only way I could rationalize and fit it into our system. I certainly felt that the nurse who became pregnant and had the baby shouldn't have to take the annual leave. Why not make her husband take his annual leave and take care of the baby if the nurse's condition was such that she could return to active duty?

We had some interesting conversations on the subject.

MAJ Gurney: I'll bet. It was a very volatile time.

BG Dunlap: Remember that when you talk about policy for women, it's not just the Army Nurses, it's women in the Army. There was a director of the WACs who had her opinion too, based on her situation, which was different than the Army Nurse Corps. So, there were some interesting conversations and discussions about that.

SCOPE OF PRACTICE OF NURSES IN VIETNAM

MAJ Gurney: We were talking about the issues related to Vietnam during your tenure as Chief. One other issue that some might ask about—and I think you alluded to it a little bit in terms of nurse satisfaction—was the scope of practice of nurses in Vietnam. Do you feel that the scope of practice of the nurses, while they were in Vietnam, differed from that of their stateside counterparts?

BG Dunlap: Oh, yes. I think this happened. There is always a difference between peacetime military and stateside civilian nursing and combat nursing. Vietnam combat nursing was a little different because they had some more sophisticated equipment over in Vietnam in some of those hospitals than we had in some of our hospitals here in the States. For instance, we had the kidney unit over there.

MAJ Gurney: Renal dialysis?

BG Dunlap: They had a renal dialysis unit over there and were doing some research on hepatitis and hemorrhagic fever, or something like that.

MAJ Gurney: The hemorrhagic fever may have been in Korea, but there was malaria.

BG Dunlap: Malaria. Malignant malaria.

MAJ Gurney: Yes, there was some really sophisticated research going on over there, too.

BG Dunlap: They had things like that in Vietnam that we normally wouldn't think of in Anzio or New Guinea or any combat area. But I think any nurse who has served in a combat area feels that they learned so much. Back in the States we have certain restrictions placed on us as far as our practice. When we're overseas, we have to do it all, and I will go again to my own experience. Having just gone into the Army Nurse Corps as a new graduate back then, the nurses couldn't start intravenous lines, couldn't put nasal gastric tubes down, certainly couldn't start transfusions or anything like that. Suddenly we were thrown into a position where we have to do it because the doctors are in surgery all the time.

The same thing happened in Vietnam. It happens in all of the wars. We expand our role. Each member of the team takes on a little different aspect of the traditional role in that profession, I think. I know this certainly happened with our enlisted personnel, particularly our 91 Charlies. Our 91 Charlie is our right hand. Many of the 91 Charlies were starting intravenouses and doing cutdowns, and suturing and doing things like that. Then, when they returned to the States and went to a medical center, they weren't allowed to do that. That created some dissatisfaction because once they had done it, it isn't that they were thrilled to be doing it, but they knew they could do it. Then suddenly, they were told, no, you can't do that, the intern does that, or the resident does that, or the RN does that.

They might say, "If my practice is going to be limited like this, maybe that is not what I want to do. Maybe I want to do something else." But there is always a difference, and it is based on the expanded role during combat.

PREPARING ARMY NURSES FOR COMBAT

MAJ Gurney: Is there something we could have done to prepare our nurses better for Vietnam, to prepare the Army Nurse Corps better for Vietnam?

BG Dunlap: The ones on active duty when Vietnam started?

We attempted, through the Medical Field Service School, now the Academy of Health Sciences, to include field nursing in our basic course and our career course. All of us on the faculty down there had all had field experience. I have to take that back. Most of us had combat time, and we knew the importance of preparation like that.

There was always the constant struggle to get meaningful field nursing experience in because we had so much to get into the program in that limited time, as you do in all military schools. We had the CONARC-required subjects, plus needed to be able to get field nursing in, but we did work on it. All nurses going through basic at least had some field experience, and that varied. We used to have them out there [at Camp Bullis] a week, and then it was cut down. At one time—

and I can't remember if it was during my time or some other time, they were just setting tents up out on the parade ground out here and letting them go through. Whereas at other times, they went out to Bullis and stayed overnight or several days and had field exercises with simulated casualties. They set up their hospital and they got casualties in and really worked through it.

We did that for basics and for the career course. We had short courses. I think we had a short course that we called Field Nursing that they could attend. I know we had a Management of Mass Casualties course that nurses could go to. Plus, they would go out to the field for a lot of that.

How could we have better prepared them for Vietnam?

I don't know. We had to try to get everything into a person's career. But we don't know at which point conflict is coming. When Vietnam came, we had people who had gone through basic and then had completed, perhaps, the career course. But we had others who had just finished basic. Some had completed it so long ago they had forgotten it. I think then they started requiring that the people at each of the hospitals had to spend a day out in the field, or something like that, so they would at least get into field uniform and have some kind of simulated exercise out there.

I don't know what else you could do.

THE VIETNAM WAR AND THE INTEGRATION OF MALE NURSES

MAJ Gurney: Vietnam was the first war for our men in the Army Nurse Corps as Nurse Corps officers. Do you think the Vietnam War helped in the integration of men, both in the actual physical role they played and in the emotional oneness that they may have developed as they were identified as Army Nurses and seen by female Army Nurses as members of their team? Do you think that that wartime experience helped with that, or did it affect it at all?

BG Dunlap: I don't know. I would say that when male and female officers served in Vietnam in a unit side-by-side, there is bound to have been better integration. You gain the respect of your coworkers, and a certain relationship is established. It's esprit de corps. There is no doubt that is carried over when they return to the States.

Those who didn't have an opportunity to serve with the men nurses like that would have to depend on their experiences here in the States, and if they are good experiences, if you work with good people, whether you are male or female, a relationship of respect develops. I think most of the resistance from some female Army Nurses was overcome. Some of the physicians also resisted the male nurses, and the line resisted it. We had some wonderful, wonderful men nurses, and they could see that after they had worked with them.

I used to say when I made staff visits during this time; it was the time of ERA [Equal Rights Amendment], women's rights, and all that marching and stuff going on. Every time I was interviewed I would also say there are two things I will not discuss. One is equal rights, and the other is male nurses. I did say this. I would

say I would be happy to try to answer any other questions you have. You can just imagine what a news reporter could do with those two subjects, and that was not my purpose. My purpose was to talk about the Army Nurse Corps. You couldn't get to the core of that message if you were distracted into talking about ERA and male nurses. Reporters would spend the whole interview and misquote you on those two subjects.

Our position, as far as nurses, was that I don't think of them as male and female. I think of Army Nurses, and they come into the Corps as Army Nurses. They are assigned, utilized, promoted, and their careers are as Army Nurses, not female and male Army Nurses. That would be the whole statement I would make, and I meant it. I meant it. Naturally, we have to take some things into consideration. It isn't a straight line like that. But that was my position, that we didn't talk about male and female Army Nurses. We talked about Army Nurses, and that shut the reporters off at the pass on that.

Reporters would ask me about ERA. Did I think I got to be a general because of ERA? I said, "I hope that I got to be a general because someone thought I was qualified to be a general." That would be it. I wouldn't say any more because I wasn't about to get into those dramatic, emotional issues when I could be misquoted.

MAJ Gurney: And have your message distorted?

BG Dunlap: Yes. Not about the Army Nurse Corps, but about those two issues, social issues. The men didn't have an easy time being accepted by the Corps at the beginning, but when you have had men and women in the career course together, in basic together, it became easier. Many of the men that came in at first had been enlisted people, and we utilized them as nurses in situations like that. There was a lot of resistance with some of our Army Nurses toward those male nurses. But thank goodness, we were able to keep our senses, and we had some tremendous men.

MAJ Gurney: What overcame the resistance?

BG Dunlap: Working with them, and there is competition. I attended the National Convention of the American Association of University Women several weeks ago. One of the proposed amendments to the bylaws was to change the article that says for membership you had to be a woman graduate of a baccalaureate program acceptable to AAUW. The amendment was that you be a graduate. It did not say man or woman, it said, "a graduate." Well, that means members could be either men or women.

Some of the speeches given on the floor of delegates there, pros and cons, were incredible. A former state president in Texas got up to speak, and I tell you, it sounded like some of the things you heard against civil rights and equal rights. She was so opposed to bringing men in. They would soon take over the organization, in her mind. I thought to myself, "yes, yes, if you let them in in large numbers, but you would be the one who let them do it eventually."

Well, the same thing happened as far as men in the Corps, but we did have some real fine men who entered the Army Nurse Corps. But they were a threat to some people. When I was at MFSS, Army Nurses in the career course came in for counseling and career planning. The men came in, and they would tell me that after they had the career course they wanted an assignment here, they wanted *this*, they wanted *that*, so they could have *this* to qualify for *this* and *that*. They knew what they wanted. They had specific career goals. The women came in, and we would start to discuss it. "Well, it doesn't really matter, wherever the Army Nurse Corps wants to assign me." You can see that that male nurse, who knows what he wants in his career, is a threat to the female nurse who doesn't care what happens.

But when he starts getting those opportunities to meet his career goals, then she thinks he is getting special treatment. But he knows what he wants, and he is going after it. You have to admire them for that. We have females who do the same thing. I came home after counseling sessions like that, and I would think, "How can we light the fire under them to get them moving?"

When I was at MFSS, I remember at that time the females weren't mamas. But the men were family people and they were thinking in terms of their own career development because they had families to support along the way. That has changed now, I guess. Now we have so many Army Nurses who are mamas and papas.

MAJ Gurney: Quite a few, yes, quite a few. This is excellent. I think I have gone through my list of questions related to Vietnam. Do you have anything else that we haven't touched related to Vietnam?

LESSONS LEARNED FROM VIETNAM

BG Dunlap: When the last chief nurse came back from Vietnam, Colonel Marion L. Minter, she came in to The Surgeon General's Office and we had a nice session with her for lessons learned. She reported closing out Vietnam nursing over there. All of those lessons learned should be part of your Historical Unit, I think.

MAJ Gurney: Yes, those tapes have actually been incorporated into the oral history program.

BG Dunlap: Good.

MAJ Gurney: Yes, I have read the transcripts of several of them; Colonel Minter's, Colonel Williams'...

BG Dunlap: Althea Williams, Rose [Ski] Straley, Pat Murphy.

MAJ Gurney: Those are the three [Colonels Minter, Williams, Murphy] that I have looked at most extensively. The others I haven't found yet. But, yes, we have those. Jeannie Caylor's was also among them.

BG Dunlap: I would hope that that type of information, those lessons learned, would be reviewed and used as part of the curriculum at the academy because we are preparing chief nurses. It should be put to use instead of it being in a file someplace. These are the lessons we learned from Vietnam. How can you prepare them? Well, these were the lessons we learned here in Vietnam, and if the whistle were blown again, they wouldn't stay in that file. We would have to learn those lessons all over again.

MAJ Gurney: That is right, absolutely.

BG Dunlap: I am sure lessons learned from Korea and from World War II probably are documented, but we had to learn them all over again.

MAJ Gurney: The materials that I received of Agnes Maley the last time I was here included a report of lessons learned from World War I. This was used in a speech in 1942.

BG Dunlap: Wonderful.

MEDICAL UNIT SELF-CONTAINED TRANSPORTABLE

Can we talk for a brief moment about the Medical Unit Self-contained Transportable (MUST)? That was a vehicle of the Vietnam era. Was it implemented before you became Chief?

BG Dunlap: The MUST. The testing for that started in the '60s.

MAJ Gurney: '67, '68.

BG Dunlap: Before then. It was done when I was at the Medical Field Service School. I have pictures of the test unit down here.

MAJ Gurney: Yes. It is on my list.

BG Dunlap: I can tell you why it is probably on your list. When General Pixley came in as Surgeon General—or not in as Surgeon General—it was before he was Surgeon General because I didn't serve under him as Chief. He was in Health Care Operations then, and he had been in Vietnam.

He was concerned about the MUST because it was not transportable. As the MUST was utilized in Vietnam it was used as a permanent hospital. It had been augmented so much that it couldn't fulfill the purpose of a hospital that you could pick up and move right quick. So he had great concern about that, and we had studies done. When we did lessons learned briefings, everyone who came in through The Surgeon General's Office would talk about the MUST unit. They had the idea that maybe what we needed, particularly in the MUST unit OR package, was a box, an expandable box.

We could use that, but we couldn't use all of the inflatable walls. We would have to go back to tentage to really be transportable. We couldn't use all of the MUST ward shelters and other structures that required the generators to keep them blown up. I can't remember how many thousands of pounds the whole thing weighed, but who was going to dedicate the transportation assets to move all of it? Not only that, but the time it took to move it, to set it up, that was not available in the combat situation.

So that was when the thinking and the studies began about using a combination of what we had in the MUST unit, particularly the OR portion, and going back to some type of tentage. The Air Force developed something. What have they developed that they have used?

MAJ Gurney: The camper kit, they are using a system of tentage.

BG Dunlap: It was some kind of transportable unit that they could drop into an area and set up a hospital.

MAJ Gurney: Yes, which was picked up from the French. The French air-transported their hospitals, dropped them in, and then they were considered disposable. They would leave them behind.

BG Dunlap: Well, of course we did that—where was it—down in Chile when they had the earthquake. We did that when we went out on emergency situations like that, natural disasters. We would set up some of our hospitals, whether it was tent hospitals or MUST units, and then leave them for the people to function out of.

MAJ Gurney: That was primarily for humanitarian assistance missions. They were left to continue functioning as a gift to the government.

BG Dunlap: Yes. But they just found in Vietnam that the MUST unit, as it was designed, was not practical to move with the troops. So they had to go back to tentage, and that is what they were working on. General Pixley became Surgeon General later on, and I think that was one of his real projects during his tenure.

Getting back to combat medicine and the field hospitals, that is the whole reason behind the MUST. I got involved in MUST in the testing of it when I was at the Medical Field Service School. [Lieutenant Colonel Katherine] "Kitty" Jump, [Lieutenant Colonel] Jean Barcus, [Lieutenant Colonel] Pat Murphy, and [Lieutenant Colonel] Edith Bonnet-Whitelaw [Bonnie] came down from Washington. They were the consultants. Pat Murphy primarily, but the others, Kitty for the OR, and so forth. They came down here where we were field-testing at the Medical Field Service School. They could observe and help work on it.

But theory doesn't always work out. It was nice to have those units that could be kept nice and warm or nice and cool, but the generators used so much fuel—and a certain kind of fuel. In the middle of this we were going through an energy crisis worldwide.

MAJ Gurney: That is right in the middle of that.

BG Dunlap: So where do you get the fuel to keep the generators going to keep the tent units blown up? How do you get the vehicles to transport them?

Army Nurse Corps Anniversary Celebration, 1975

MAJ Gurney: We were just beginning our discussion of the February 1975 celebration of the Army Nurse Corps' 74th anniversary. General Dunlap, tell us about those programs and why they were planned the way they were.

BG Dunlap: The anniversary of the Army Nurse Corps in February of '75 would be my last ANC anniversary on active duty. I knew I would be retiring in September '75. I had served with all of the living Chiefs of the Army Nurse Corps at that time and I felt very close to them. Although it wasn't the 75th or the 50th or anything like that, I wanted to have something special because it was the last one I would celebrate on active duty.

So I wrote to each of the former Chiefs and asked if they could come in. I even called some of them. I hoped they could come to participate in a celebration of the Army Nurse Corps anniversary. We planned to have the memorial service at the chapel out at Walter Reed, with the idea that the memorial service would not be a sad memorial service, as some of them are, but rather it would really be a memorial celebration.

The only one that could not come in was Colonel Phillips. Colonel Phillips, a few years after she retired from the Corps, entered a cloistered order, a convent, and she was quite ill, in an invalid status really. But she was the first Chief of the Army Nurse Corps I had met. I was stationed at the Fourth Army headquarters at the time.

I wanted so badly for her to be able to come. I called the Mother Superior and asked if it would be possible for her to come. She said, "No." I said, "I will send an Army Nurse out to fly with her." And she wasn't able to do that. I already had a volunteer who would go out there to fly with her to bring her in. The Mother Superior said she wasn't able to do that.

Then I asked if I could set up a teleconference so that when all the other former Chiefs of the Corps were in Washington, we could have a teleconference and they could talk with her and she could talk with them. The answer was no, because they were afraid that might precipitate a stroke. They said when she got excited or got real emotional, she had difficulty talking, and they were afraid that this might not be the best for her. So it was a big disappointment that she couldn't be included because she was the senior living Chief at that time.

Colonel Bryant was the next senior and then Inez Haynes, Peg [Margaret] Harper, Mildred Irene Clark, and Anna Mae Hays. So they were all there. We had a beautiful service at the Memorial Chapel at Walter Reed. The WRAIN Chorus sang. Edie Nuttall, the assistant chief of the Corps, read scripture. Lieutenant Colonel Larry Washington sang the Army Nurse Corps song. He had a beautiful booming voice.

From there we went over to the officers' club and had a brunch honoring the former Chiefs of the Corps. WRAIN students modeled the history of the Army Nurse Corps in uniform. The Surgeon General was there. That is where the picture was taken that is hanging on my wall. We made copies for each of the former Chiefs, and The Surgeon General wrote a note on each of them and signed them.

HISTORICAL DISCUSSION

The next day we set up a bus to take us to Fort Detrick [Maryland], where the Army Historical Unit was at that time. Dotty [Dorothy] Zalabak was the nurse assigned there. We went out that morning by bus, met in the conference room in a very informal setting. The former Chiefs sat around the table. We just wanted them to start recalling the significant happenings of their tenures. This was one of the most exciting experiences for me because I was on active duty during their tenures as Chief, and it was fascinating to hear them discuss what they considered the most significant events during that time.

I didn't know if I was going to be discussing it from the perspective of when I was in the Assignment Branch or as Chief of the Corps, and the same was true for them. Colonel Bryant said, "Now, Inez," to Colonel Haynes, "was that when you were in the Branch or when you were Chief" because there was this overlapping relationship. I have said all along that we start things during the time we are Chief, but we don't finish many of them. The next Chief builds on them and continues with the program. They could change it in certain ways. You could see that the whole time as it went around the table and as you read the transcript. It was fascinating to see what they particularly considered significant during their time as Chief.

As far as Colonel Bryant was concerned, it was AR 40-6. Through that we were able to get the nursing service as a legitimate service and we gained functional control of the enlisted personnel. But we also got into career planning during these periods. Mildred Irene Clark was instrumental in that.

During Inez Haynes' time, between '55 and '59. . .

MAJ Gurney: That would be the accession of men, with the first one entering in '56.

BG Dunlap: Well, here also you have Department of Nursing [Division of Nursing, Walter Reed Army Institute of Research] established, with Major Harriet Werley, and Lieutenant Colonel Maggie [Margaret] Ewen assigned to The Surgeon General's Office. President Dwight D. Eisenhower signed Public Law 85-155 expanding the career opportunities for Regular Army Nurses.

We identified Colonel Phillips with her work with the reserve during the '50s.

MAJ Gurney: The Army Nurse Corps Reserve was established in '47-'48 with the establishment of the Army Reserve, and so that whole period from '47-'48, to when they became preoccupied with Korea, was spent in establishing a system for an Army Nurse Corps Reserve.

BG Dunlap: I first met her in 1950 when she was down here at Fourth Army attending a reserve nurses conference that Colonel Short sponsored here. I always relate her to the reserves and also the beginning of career planning and the different career courses that were being offered. Colonel Bryant followed through on this type of thing and Inez Haynes and Peg [Colonel Margaret] Harper picked it up. It was during Peg Harper's time that the WRAIN program was being debated.

For Mildred Irene Clark, I think of the ASNP [Army Student Nurse Program], although it started before her time. She was assigned in recruiting, procurement in The Surgeon General's Office, to get the program going. I think of Mildred Irene in regard to recruiting because she pushed for general officer status. Mildred Irene is the person who really laid the groundwork to get the Chief of the Army Nurse Corps a general officer position. Unfortunately she was not the first one.

MAJ Gurney: How did she do that? What did she do to accomplish that? Was it a lobby effort?

BG Dunlap: She worked through the American Nurses' Association (ANA) to get them to push for the star for the Chief of the Army Nurse Corps. Anna Mae (General Hays) then was our first Chief of the Army Nurse Corps to wear the star. Anna Mae was the one who called in the civilian and military consultants, to begin thinking about defining the role of the nurse in the ANCCP program, which then I picked up. It became the Army Nurse Clinician Program.

It was most gratifying to watch as they sat around the table discussing these different things. They had so many laughs about different things like the people they worked with. "Oh, my goodness, you remember him, how he gave us a hard time when we were trying to get this done or that done." They'd be referring to some MSC or MC or someone they'd had conflict with.

Uniforms, every Chief has gone through uniform problems like the Hattie Carnegie uniform.

MAJ Gurney: Oh, yes. That was your all-time "favorite."

BG Dunlap: Why did we have that uniform? The effort again was to get away from being so masculine looking, with the tie, and to come up with a better uniform.

Every chief nurse also has been faced with problems related to housing for Army Nurses. Recall that we lived in nurses' quarters and had one room and a community bath and a community room that was known as the kitchen. There was one refrigerator for everybody in the whole double-deck barracks. I am thinking of Splinter Village here.

From there we advanced to some of the old cantonment buildings where they knocked out a wall and we had two rooms. One was a sitting room, and one was a bedroom. We shared a bath with someone on the other side with the same type

of arrangement. That was what I had at Fort Jackson. But we still had a community kitchen at that point.

As they discussed these things, they went through housing and the improvements that were made along the way in housing. That is all documented, and that is the kind of discussion that I really wanted. Lieutenant Colonel Polly [Pauline] Maxwell had been working on the history of the Army Nurse Corps and doing a beautiful job. She had included such detail. But I thought that this would at least cover the period from when Ruby Bryant became Chief of the Army Nurse Corps in '51 to '75. Of course, this group also knew Colonel Phillips, Colonel Blanchfield, and Colonel [Julia] Flikke. Some even knew Major [Julia] Stimson. So this conversation could reach back to '37, when Colonel Stimson was Chief. This would bring us at least some type of historical data on tape and then later in transcription. That was the whole intent.

I had a dinner party that evening out at the Evans Farm Inn. There were some that came into Washington for the occasion and we had a tremendous time out there that evening. We also had members of The Surgeon General's Office; Army Nurses also assigned there. The senior members of the Corps joined them in recalling some of their experiences.

I was selfish, I guess. I really wanted that before I left because I wouldn't be in a position again to have that experience. I wanted it documented as part of the Historical Unit as much as possible and then we would be able to share the experience with many others.

That was the first time that Peg Harper had been back in Washington since she retired. Everybody was so excited. Peg Harper was coming back! Not only just the Army Nurses and the former Chiefs, but the people in The Surgeon General's Office, active and retired, who had worked with Peg, were excited. She was respected and loved by those who worked with her, and they were excited that they were going to see Peg Harper again. They were excited about seeing all of the Chiefs, but particularly because this was the first time Peg had come back. The others had all come back for some occasion or another, but not Peg.

So it was an exciting time.

MAJ Gurney: I bet it was.

BG Dunlap: I think it contributed to the history of the Corps by having that transcript available and the discussion documented.

And I know what the last question is on your card there.

MAJ Gurney: But we won't talk about that. I think I have one more question on the history, and then I think we will quit.

KALISCH ATTEMPT TO PUBLISH A HISTORY OF THE ARMY NURSE CORPS

If I remember the literature I have seen in my files correctly, the Office of the Chief, Army Nurse Corps, received a volume that was a history of the Army Nurse

Corps from a publisher for review. It was written by Beatrice and Peter Kalisch. It was an independent effort on their part, and the publisher was getting ready to publish it. They asked the ANC for a review and opinion. I have seen that review, and it was over your signature.

BG Dunlap: Who signed my name?

MAJ Gurney: I thought that maybe you might remember something about the details about that and what the ANC had to say about that volume.

BG Dunlap: You have seen their comments?

MAJ Gurney: Yes. I hoped we could discuss the specifics.

BG Dunlap: It wasn't acceptable.

MAJ Gurney: No, it wasn't.

BG Dunlap: Okay. The detail, I don't remember exactly all about that, but I remember that when this volume was sent for comments it was staffed to senior Army Nurses for recommendations. We felt that it was not factual and did not portray the Army Nurse Corps as we knew it and as we wanted it published. I think that is basically what my comments are, without going into specifics, because I can't remember just exactly. You probably can.

MAJ Gurney: Well, the part of the comments that I remember is that it was primarily unreferenced, or very sparsely referenced, and in that way it wasn't a scholarly work in terms of providing adequate bibliographic notes.

BG Dunlap: It wasn't factual.

MAJ Gurney: The references weren't there to document what it was saying. I think the ANC's position was that it was not good history if it was not documented. That is what I remember from the comments.

BG Dunlap: Which is like what I am telling you now after all of these hours that we have been together. This is as I remember it, and certainly one's memory sometimes plays tricks on you years later. After all, I am relating my experiences as I remember them over 33 years, going back to 1942. I hope that I have remembered correctly in most of these discussions. But as I have said, the details of some of these things elude me. I can remember the general gist of it, and I think I am pretty good at remembering people and names and places and so forth. But I would say that when we get into it, if you wanted to publish this as the history of the Army Nurse Corps, or of my career, certainly I would want it documented, especially for specific things. But the point is that this is as I remember it, and I felt

the same way about that particular publication. If you wanted to publish this history as the gospel truth or "official" history, you would have to have go ahead and document further.

For instance, the establishment of the Army Student Nurse Program, what was the AR that established that? Or the WRAIN Program, what was published to discontinue the WRAIN Program? I think this is important historically because I am sure this oral history of mine is going to be prefaced with the specification that this is an oral history as General Dunlap remembers her career. If I could dig out some of those things, I would have. We would have more to document. But you have things on file up there, and of course we have regulations; just like it has been published in here, certain things are published regulations.

MAJ Gurney: As we say in history, those facts are verifiable through official records.

Special Mobilizations

MAJ Gurney: There were a couple of events that occurred while you were Chief that required some quick mobilization and garnering of resources.

In April of 1975, with the evacuation of Indochinese refugees from Southeast Asia, there was an operation that they called Operation NEW LIFE and then later Operation NEW ARRIVAL.

What were those activities, and how did they affect the Office of the Chief?

BG Dunlap: The Surgeon General was given the responsibility for providing health care at the centers that received refugees to be processed to get into the country and then at in-country centers once they were in the country. Once The Surgeon General is given responsibility for that, the health aspects of it and health care, then it becomes his job to organize the operation per se, which pertains to health care. As a member of The Surgeon General's staff, I was responsible for providing the nursing personnel to support this type of operation. We sent a group from Hawaii to Guam to provide the health care facilities. Guam was primarily a Navy base but we sent an Army group in there. Lieutenant Colonel Jean Hoppe headed up the Army's center.

I hope you all get her on tape.

MAJ Gurney: We really should.

BG Dunlap: She later was chief nurse at Fort Ord. I think that was where she retired. But Jean did a tremendous job over there.

It was almost incomprehensible, to have these large numbers of refugees, boat people from Indochina, escaping with nothing. Many of them were in poor health, suffering from all kinds of medical conditions. They suddenly descended on us, needing care. They so appreciated even the minimum amount of care that they could get, just anything to feel safe and to be taken care of. They were a very appre-

ciative group, and as far as discipline and management, there were really no major problems. As far as health care, with the large number of children, they had all kinds of infestations and everything else that needed to be taken care of. I can't remember the number of nurses we actually assigned over there, but it is in the reports in The Surgeon General's Office, I am sure.

They didn't keep the refugees on Guam. That was the screening for them to get on into the States. In the States, the refugee centers included Camp Pendleton in California. The Navy was responsible for that refugee center. The Air Force ran the center at Eglin Air Force Base in Florida. We had Fort Chaffee, Arkansas, and then later on Indiantown Gap, Pennsylvania.

Velma Barkley was the nurse we sent to Chaffee. I followed that one quite closely because I had served two tours at Chaffee. The first was prior to going overseas in World War II, and then later I was chief nurse there when we closed it in January of 1950. It was reopened in August of 1950 and had been opened and closed so many different times. Of course, Chaffee was the typical cantonment-type hospital with three ramps and the service ramps in the back, the fourth ramp. We used to say it was a third of a mile from the end of one ramp to the other end of it. But these facilities had been kept in good condition for that type of construction to accommodate any expansion or mobilization we might have to do, even in wartime, not just for this refugee situation. To get the whole picture of this operation, you would have to talk to Velma Barkley, who lives—I think she is down in Florida. She is a member of RANCA and she always comes to the convention. She is a real good friend of [Brigadier] General Elizabeth Hoisington and [Colonel] Bettie Morden. Colonel Morden was the deputy director of the WAC.

We had problems at Chaffee, because of the large numbers of people, their poor health, and the frightening situation they were in. I remember when we took care of World War II Filipinos who had been tortured by the Japanese. When we started to give intravenous fluids to them, they thought we were going to torture them. We were coming at them with a needle, and because of the lack of ability to communicate, we couldn't make them understand. We had this same problem with the refugees. Any time you take care of people who you can't communicate with, it doesn't have to be from another country, there is that fear of what you are trying to do. Since so many of them had been tortured and under those conditions, they really weren't so sure that we weren't trying to do some of those things to them, too. Velma can certainly fill you in on the details of how that operated. She kept me well informed. At that time they were under Health Services Command, and the chief nurse at Health Services Command made recommendations as far as staffing and what they needed in terms of people. She tracked what was needed and could move people from one facility to another. Velma kept both the chief nurse at Health Services Command and me well informed of what was going on.

When Fort Chaffee filled, we had to expand. We went into Indiantown Gap, and that is when Lieutenant Colonel Vera Nolfé went in to be chief nurse of that unit. We encountered a different problem up there. The Vietnamese had come from a tropical climate, and you know it gets cold up in Indiantown Gap. It gets very cold up in Indiantown Gap. So although they were in old cantonment type

facilities, and I think they had some tentage up there too, they had a large number of pneumonias as a result of the climate. They weren't used to that. So it became a different operation almost, based on the requirements of the climate and the condition of the people. They were already in a weakened condition and then exposed to a hostile environment. Both of the chief nurses did a tremendous job, and we really utilized our 91 Charlies and our enlisted personnel in caring for a lot of these patients. Remember that we didn't have a large supply of Army Nurses to start stripping all of our hospitals to provide the same ratio of professional nurses to patients that we might have in some of the hospitals. We didn't really need it with our good enlisted people.

MAJ Gurney: It was almost custodial or minimal care.

BG Dunlap: Except they were not well.

MAJ Gurney: Not entirely, but their needs are different than hospital inpatients.

What are the activities in the Office of the Chief when an event like this begins to unfold and you realize that it is going to require a massive mobilization of medical support? What would happen in your office, or what did happen?

BG Dunlap: First of all, as a member of The Surgeon General's staff, I was included in the planning and the briefing of the plan. My part, just as in any other thing, was to provide the nursing services, the nursing care required. This was one area where our community health nurses got involved, too, because we get into immunizations and everything else connected with preventive medicine.

Once the Chief Nurse [Chief, Army Nurse Corps] is aware of the total mission and is assigned her responsibility by The Surgeon General, then the Chief Nurse meets with her staff in The Surgeon General's Office. We always laugh when we say "her staff" because in reality, that consists of the assistant chief of the Army Nurse Corps, an administrative assistant, and a secretary. But there are also Army Nurses assigned in the other divisions of The Surgeon General's Office.

I held a monthly meeting. I think most chief nurses have done this. The monthly staff meeting included all of the nurses assigned in The Surgeon General's Office so that we could share what is going on in the total Surgeon General's Office and could support each other. So I had a meeting with my own staff, and we planned how each one would fit into this.

We had Health Services Command [HSC]. Health Services Command was responsible for most of the hospitals in the Army, except Europe and Korea. The coordination has to be with the chief nurse and the chief nurse of HSC because it is at the HSC level that they are going to really be operational as they are in our health care system. They are in operational control there, where The Surgeon General's Office is more oriented toward policy and strategy. The Chief Nurse certainly needs to work very closely with the chief nurse at HSC. The chief nurse at HSC knows where staff are. You never have too many staff, but she made recommendations related to where we might be able to take staff. The orders then have

to come from The Surgeon General's Office unless they put them out on TDY or something like that.

So it becomes a really closely coordinated operation. Then, I had to have the feedback about what was going on down there because it works both ways in this communication. I, as a member of The Surgeon General's staff, could provide The Surgeon General with the nursing recommendations. I think it has been the history of the Army Nurse Corps in most staff positions at a headquarters level, the Surgeon, or The Surgeon General, or whoever is in command depends a great deal on the input from his chief nurse. He recognizes that the nursing function is not only a 24-hour function, but also it—I was going to say infiltrates, but “infiltrate” can be positive, can't it?

MAJ Gurney: Sure.

BG Dunlap: It “infiltrates” all aspects of health care operations, whether it has to do with coordinating food service or any other function. We had to be sure that the patients got the things that they will eat, and when you're dealing with a culture that is used to having rice and doesn't want to eat our frijoles, it's important. That wasn't what we have all the time, but we saw this in World War II when we had Japanese prisoners at our hospital. We had a big prison camp, and we prepared the food. The same food we had in our mess hall they would load up to take down to feed the Japanese. We found they weren't eating. They didn't want to eat our food. So we had to make up big kettles of rice and fish. That is what they wanted. Then they ate. Well, I am sure the same is true of our people. When our people were POWs, they didn't relish rice and some of the things that they had to eat.

So the role of the chief nurse in any situation like this, whether it is down at the operational level or at the staff level, is one of observing, evaluating, and recommending to those who make policy decisions regarding what they think is best in the situation.

I did not visit Chaffee. We didn't have the budget for it. This was in '75, and I think you will find that not just the Chief of the Army Nurse Corps, but also every Chief of each Corps getting ready to leave office finds that the last year goes so fast. Anyone leaving a job always wants to finish up all those things that they have wanted to do and haven't had time to do. This was April of '75 and I was leaving office the first of September. So much had to be done.

MAJ Gurney: What did we bring out of that experience, Operation NEW ARRIVAL/NEW LIFE, that had an impact on the ANC?

BG Dunlap: I think we had learned from other natural disaster experiences or similar situations like Yugoslavia's earthquakes, Chile's earthquakes. It was not like our Vietnam experience, where we had Army Nurses assigned for a long period of time during the Vietnam War. We already had indoctrination to the situation over there and we knew the people. Unlike that, going in for an earthquake, like when

we moved into Yugoslavia or Chile, where we don't know the people, we had to establish a relationship there.

Our nurses in Vietnam already had an understanding and appreciation of what was going on over there, the needs of the people, and I think as a result of it were more sympathetic to some of the problems that might occur because of the difference in cultures. Remember that our whole country wasn't sympathetic to the situation over there. If we had not been in Vietnam we wouldn't have that advantage, but nurses and health care professionals who had served over there looked on the refugees differently than some of the others who didn't go to Vietnam.

We put into operation our emergency plans. At each level, each organizational level, it was extremely important to have emergency plans and keep them updated. I remember, throughout my career, when we had to mobilize large numbers. Do we have proper uniforms for them? If they have to leave on short notice, what provisions are made for them, for those who have families? What provisions are made for nurses who are single and have apartments, pets, and cars? This takes the total operation of the whole headquarters, wherever that might be. If we are going to pull a nurse out to go to some place quick-like, we have to have our mobilization plans and emergency plans at the organizational level. In the same manner the individual has to have their emergency plans updated at their level so they immediately know who is going to take care of their things, people, family, apartments, and things like that. We can't let that delay the operation.

MAJ Gurney: That is right.

BG Dunlap: Sometimes that is pretty difficult, particularly now that we have so many in the Corps, male and female nurses, who are married and have families. I think our single people sometimes even have more trouble. Maybe I am a little prejudiced there, but we don't have a wife, or a spouse, to take care of the things while we are gone. We have to depend on friends.

But the greatest importance is having your mobilization or emergency plans [family care plans], and having people familiar with them. This includes such things as wills, powers of attorney, having uniforms. I don't know what the policy is now because the policy on field uniforms has changed off and on. It used to be we had to have our field uniforms packed. I still have my footlocker packed out there with my field uniforms in it and other items which I no longer need. It's all ready to go.

Then we went through a period where we were not issuing field uniforms as they came through basic because of budget restrictions. The uniforms were not available. They said they could have one set of the field uniform. So that has changed, and I don't know what they do now as far as requirements for having field uniforms.

MAJ Gurney: We buy our own uniforms. There is much less availability now. Of course, then they send us off to tropical climates with a uniform that weighs eight pounds.

BG Dunlap: This is right, and this is something that chief nurses have to consider. Whether it is the Chief of the Army Nurse Corps or chief nurse of Health Services Command or the chief nurse at a hospital where the staff are coming from, it is a serious consideration. Headquarters tells you that you are supposed to send so and so and so and so out to join this unit and then you are the one who has to be sure that before they leave your facility they are properly clothed and equipped through logistics at your hospital there. The chief nurse is responsible for the nursing personnel and to see to it that they depart as they should. It filters down through all of the command, and then as the problems are identified, they don't filter or flow, they fly back up to the headquarters level.

Decision-making in the Office of the Chief

MAJ Gurney: I would like to go into another topic that is more conceptual perhaps, not necessarily connected with an event in particular. I think we would be curious to know what the decision-making process is like in the Office of the Chief. Are there any patterns that lead to successful decision-making? How are decisions made? What is the process? What worked for you?

BG Dunlap: It is individual, based on the Chief of the Army Nurse Corps. There is the formal organization in The Surgeon General's Office that one has to function within. It had a certain organization and policies and so forth. When it comes to decisions, it is based on the Chief's own system; how she arrives at decisions is based on her own experience and method of operation. There are some of us who believe in utilizing our staff as fully as we can. There are some who kind of make unilateral decisions. Many of their decisions are unilateral as opposed to utilizing the staff.

I know how we always make fun about committees. If you want to delay anything, well, appoint a committee. But the Chief of the Army Nurse Corps has such wide responsibilities it is impossible for her to know everything going on, all of the pertinent facts she needs to know to make decisions. And it is impossible for her to collect all the facts herself. She has to depend on staff.

The first thing is to have a staff that understands your way of operation. You need a staff that is loyal and honest with you. You must have a staff that presents the facts and recommendations as they see them, not as they think you want to hear. This staff must be willing to enter in some healthy disagreements with you. This staff must have great capacity for work because people do not realize the work under pressure that goes into an assignment in The Surgeon General's Office. Suspense dates up there are unrealistic, and those suspense dates are inserted all along the organizational chain. Whether it is at the Surgeon General's level or up at the DA or DoD level or even at the congressional level, they are just unrealistic. I realize that more and more as I am in retirement and deal in the civilian community. Their people don't know if they are going to be able to get this done in a month or two months. I just shake my head. I tell them over the Christmas holiday we had to come up with a budget for the whole next year or something

else that involved long-range planning. In the decision-making process there is so much information that the Chief Nurse needs to know before she makes a decision, whether it is a recommendation to The Surgeon General or it is a decision that she has the authority to make, and follow up with action.

I held a morning meeting with the assistant chief of the Army Nurse Corps. Each morning we would sit there and discuss what was pending because the Chief of the Army Nurse Corps is out of the office a great deal of time. She may be within the Washington area, within The Surgeon General's Office, attending some of the many staff meetings. I can imagine what it might be like now with the physical separation of the offices.

When I was Chief, most of the time we were in the Forrestal Building. The whole Surgeon General's Office was in the Forrestal Building. So coordinating within The Surgeon General's Office was just a matter of working within the building, although that takes time and removes you from your own particular office. But then if you were coordinating with DA, that was across the river at the Pentagon, and we were going back and forth between the Pentagon and the Forrestal Building to attend meetings. Ultimately we were in the Pentagon, which was only the last part of my tour. At that point The Surgeon General's Office was in the Pentagon except AMEDD PERSA, which was at Buzzard's Point. We still had the Historical Unit at Fort Detrick, and we worked closely with them. We also had WRAIN within the Washington area.

The Chief of the Army Nurse Corps is out of her office a good deal of the time, and it is the assistant chief of the Army Nurse Corps who is the operations officer as far as I was concerned. So it was important to me that each morning the Chief and the assistant chief sat down and reviewed what was pending and what we had planned for the day. Now, that doesn't mean we always did what we had planned for the day at that point because so many things come up, it changes. But at least we knew where we planned to go for that day. There were very few days that both of us were in the office all day together because often the Chief is out of town on visits. It is the assistant chief who is in the office and provides the continuity there. She represents the Chief in her absence at the staff meetings. That is why it is so important that the Chief and the assistant chief feel the respect and loyalty to each other.

Once a month I held a meeting of all of the nurses assigned to The Surgeon General's Office, as I indicated before, so we could share what was going on. As projects or problems came up, we could call people up to the office to talk with them about a specific problem. For instance we had the nurse consultant in The Surgeon General's Office. She was down in Health Care Operations in the Consultants Division.

I certainly worked with the Health Services Command chief nurse closely to gather the information I needed to make the decisions. One of the problems that one has in an office like that is files. When the IG comes in you can only have so many inches of files in your cabinet. When I was in Okinawa my NCOIC took out all the files above those limits and kept them in the trunk of his car until the IG finished his inspection. Then he brought my files back in for me.

MAJ Gurney: Oh, my gosh!

BG Dunlap: We didn't do that in The Surgeon General's Office, but I learned we must depend on our files because things go in circles. We discussed yesterday at length about some of the different problems that we are facing today, whether it is housing or uniforms or civilian nurses, all those different things. It goes in circles. Every chief nurse is faced with it, and it is important that there is historical information in the files that she can refer to in making her decisions and responding to some of these.

I may have told you earlier about the increasing percentage of civilian nurses, converting military spaces to civilian spaces. We had faced that when I was chief of the Army Nurse Corps Assignment Branch. Major Rose Straley was the assistant chief. We had responded to that during that '66 to '68 period over there. Then when I became Chief and she was the assistant chief of the Corps, we were faced with preparing a response to the same problem. This was in the '73 to '74 time frame. So I asked the secretary to pull out from the files any information she had in there. She pulled one item out, and it was a copy of a response that Major Rose V. Straley had prepared. The same basic argument existed. All we had to do was change the statistics and her signature and make her a full colonel instead of a major.

MAJ Gurney: Oh, my gosh. Isn't that wonderful.

BG Dunlap: It was important to the decision-making process that we have available the historical data about the problems that had been faced in the past, especially that material related to that same problem as had been faced in the past. What was the response? Was the situation then different than the situation we faced today? If it is different, then we have to come up with all new supporting facts to base our decisions on. But frequently they are not. We are still faced with mobilization. We are still faced with training. It's the same problems, the basic problems, but statistically they were different.

Once the facts are presented to the Chief, she has to make the decision and live with that decision then. Once her decision is made, it is important that the reasoning behind it is made known to the assistant chief. The way I functioned, it was a joint decision most of the time, a position that we agreed on. Then the response was our response. It was not very often that I made a unilateral decision without considering the others.

Once I made the decision, that is my decision and I am responsible for the implementation of the action and any repercussions from that decision, good and bad. That is the decision-making process in too many words. But you make the decision and you live with it. But if it is one that is controversial, I think it is important that people understand. People need to know what is behind a decision.

POWER BASE OF THE CHIEF

MAJ Gurney: During your tenure as Chief of the Army Nurse Corps, what was your power base? Where did you get your power? What additional sources

could you call on to support your power base when you needed to implement a decision?

BG Dunlap: Well, first of all, in The Surgeon General's Office, the relationship of the Nurse Corps Chief with the other Corps Chiefs is very important. I was fortunate in that during my time, with the exception of one, I had a very good relationship with all of the other Chiefs. Remembering back to the old MFSS, some of them had been students of mine, or we had worked or had been students together. For some, we had been on staffs together before. Just as you have in your Command and General Staff, your classmates are at the leadership level now and you have this relationship established.

As an example, the Chief of AMSC was Colonel June Williams. June Williams had been a dietetic intern when we were stationed at Brooke together in 1946 to '49. She was a young dietetic intern, and I was a first lieutenant, later a captain at that time. So we had known each other off and on during our careers. She had taken the hospital admin course, also. So we already had a comfortable, respectful relationship there. I had known the other Chiefs of the Corps in different capacities. That is very important because if The Surgeon General has a project or position paper that you have to respond to and you are able to sit down and talk it through with the Chief of the MSC or the Chief of the Dental Corps or AMSCs, you have an understanding. That is a power base right there, and I used that because if I had something that related to nursing it was important to me that I was able to discuss this. We would have an understanding among ourselves before we got to the staff meeting and before it got to The Surgeon General as a position.

It really was something that we could support each other and the positions we took. We couldn't always have full agreement. You don't expect to. But at least I got a lot of support from other Corps Chiefs. I also got a great deal of support from the chief nurse at Health Services Command and from the chief nurses in our hospitals. The professional associations offered support, and I don't know if you want to get into it at this point, but also I worked closely with the WAC [Women's Army Corps]. I will just mention that, and we can get into it in more detail.

Also, we have the organization of the Federal Nursing Council. This is the Chiefs of the five federal nursing services. Dr. Faye Abdellah had been with U.S. Public Health almost as long as I have been living, I think. I am being facetious. Virginia Longest had been Director of the VA Nursing for a number of years, and Admiral Alene Duerk was Chief of the Navy Nurse Corps. We had known each other from the time when I was in the Assignment Branch and she then became the Chief of the Navy Nurse Corps. The Air Force Chief Nurse, Ann Hefley, I had not known that much.

We made up the Federal Nursing Council, and we met regularly. We rotated chairmanship. All of us had common problems in federal nursing, and certainly we served as each other's consultants, individually or otherwise. There are few people wiser than Dr. Faye Abdellah. I could call on Faye, or any of the federal nursing chiefs, and they could count on me.

Then, in civilian nursing, we had the National League for Nursing and the American Nurses' Association. Plus Jo Eleanor Elliott was out at WICHE [Western Interstate Commission for Higher Education]. She had been a former president of ANA and a great supporter of the Army Nurse Corps.

I also used the former Chiefs of the Corps as consultants. Power base? Certainly they had some impact.

MAJ Gurney: As you are describing the folks who constituted your power base, was there any inroad or any relationship with Congress or anyone in Congress that could add to your power base?

BG Dunlap: I had no power base as far as Congress was concerned. I never sought any power base in Congress. I possibly could have contacted our representatives from Texas, but I didn't. I never felt the need for that.

I went to The Surgeon General's Office as Chief with such a varied experience that I considered that my power base. Even in retirement it is still my power base because I had worked as a clinician in Army hospitals, small and large. I had been a chief nurse of a small hospital at Chaffee, had been chief nurse of a hospital in Okinawa, and chief nurse at Walter Reed, although for a short period of time. I had experience at the Army Area level on a staff as a recruiter at Fourth Army headquarters and then as chief nurse at First Army headquarters. So I had interfaced with not only the medics but also the line in those staff relationships. I had taught at the Medical Field Service School. During a five-year period I taught in all the courses from basic to advanced course, officer and enlisted. You establish a power base right there, in that you know these people. I had been a student in hospital administration and many of my classmates then progressed in their careers just as I did and assumed a responsibility and positions of authority and command.

Based on these experiences, when I got to The Surgeon General's Office my real power base was that I knew so many people throughout the AMEDD. If it had something to do with an IG report, nine times out of ten I knew that IG. One that I worked with very closely had been a student of mine when I was teaching in hospital administration, and he was now the IG. I didn't hesitate to give him a call and talk with him about an IG report that had come in or some concern I had, if he was going to be making an IG visit or something like that. That was the real power base that I enjoyed. Although we didn't have formal career planning, those who took care of my assignments saw that I had progressive assignments. Plus, being in the position of chief of the Army Nurse Corps Assignment Branch for a period of time and interfacing with commanders and the chief nurses at the different levels, I knew people throughout the AMEDD and that was a power base.

As far as Congress, no. As far as the DA staff, I had not served with the Chief of Staff or the Vice Chief of Staff, and I really had not had that much relationship with them. As a matter of fact, when I was chosen as Chief of the Army Nurse Corps, one of the first questions that I was asked was, have you been The Surgeon General's chief nurse? The Surgeon General was [Lieutenant] General Hal B.

Jennings. I said, he only knows me because we had lunch together one time when I was chief nurse at First Army and he came out to a luncheon the Surgeon was having out there. I had never served with him. People couldn't figure it out, "How did you get to be Chief if you didn't know him and he didn't know you?" We soon got to know each other!

But that was kind of unusual. We had had a Surgeon General, [Lieutenant] General Leonard D. Heaton, for ten years, and he was not only The Surgeon General, he was a practicing surgeon. He lived in Quarters One at Walter Reed, and Walter Reed was the hospital where he practiced his surgery. He did surgery on many of our congressional and military leaders and leaders of foreign countries. They were his patients. They were hospitalized at Walter Reed and he made rounds and he saw those patients, and he also functioned as Surgeon General. So his power base, part of it, was the relationship that he had established with members of Congress, DoD, DA staff, embassy staff, and any other staff in the federal complex who had been his patients. He had a real physician/patient relationship in addition to being a staff relationship as The Surgeon General. I think during his tenure that possibly filtered down through the organization in The Surgeon General's Office.

People who had been assigned to Walter Reed had been a part of the care of those patients. We had chief nurses who had been assigned to Walter Reed for a period of time and had been a part of the care of those patients, General Heaton's patients. They knew them again in a professional relationship of nurse/patient and then a later staff officer relationship. I think that is a real power base. I have seen in subsequent years that power base possibly eroded based on the relationship of The Surgeon General with the whole federal complex.

MAJ Gurney: The decision-making process is a very fluid thing that changes with the situation and the individuals involved. Was there any system or technique that absolutely didn't work? Could you tell us right now what it was that just did not work in this environment?

BG Dunlap: You have thrown me a curve.

I am a basic believer that if you have a formal organizational structure, even those structures might be very difficult to work with. If the informal organizational structure is compatible, you can work through the informal organization. Sometimes you can make the most difficult formal organizations work by having an effective informal organization. If you do not have that informal organization, then it makes the formal organization very difficult.

I will be candid with you; the one Corps Chief who I indicated to you that I did not have that good a working relationship with was the Chief of the Dental Corps. He also commanded AMEDD PERSA. This was a person I had never encountered before so I didn't have the relationship with him that I had with other Corps Chiefs. He had not been in the hospital environment, which was my basic preparation. We had a new concept, a new formal organization, AMEDD PERSA, whereas when I had been chief of the Branch we had a director of Personnel and a deputy director of Personnel. The Army Nurse Corps Assignment

Branch came under those two, and I worked very closely with them. The Chief of the Army Nurse Corps didn't have control over the director of Personnel, and the deputy director of Personnel. I had to go through them, which caused us to have two chains. The nurses in Army Nurse Corps Assignment Branch coordinated with the Chief and took her recommendations. They kept her informed, but in the formal organization the director of Personnel and the deputy director were the ones that they came under really in the organization. But they were not a separate command. They were on the staff of The Surgeon General just down the hall.

Then when you came to AMEDD PERSA, this removed all of the Corps personnel branches and put them under the commander of AMEDD PERSA. He became a general officer. There was a different relationship. When we were in the Forrestal Building, we were in the same building, but it seemed that once he became commander of AMEDD PERSA, under this individual, the relationship changed. There were many papers staffed about the role of the Chiefs of the Corps and the Corps branches including the position that we really should have no relationship with them, removing us far, far away from them. They suggested the chiefs of the branches would not even come over to seek the advice of the Chief of the Corps or let the Chief of the Corps know what was going on.

This was really a difficult environment. It was not a healthy environment. Fortunately, the deputy at AMEDD PERSA was one who had been in the other organization, and I had functioned with him when he was deputy, well no, he wasn't deputy chief of Personnel, he was in Special Projects. I had worked with him under the old system, and we had a beautiful working relationship there. So I was able to work within the system because I had him as a point of contact and I had the chief of the Army Nurse Corps Assignment Branch, Edie Nuttall, who had worked in the old system, too. We could function the way I felt that we should function.

Under the personnel system now, as I understand it, it must be very difficult for the Chief of the Army Nurse Corps to have it still further removed under a DA, rather than an AMEDD, office.

MAJ Gurney: If I understand you then, in your decision-making process, if you had attempted to coordinate going directly to the commander of AMEDD PERSA, you may well have been blocked in that effort. But the strength of your informal relationships, your ability to perhaps go to the deputy chief and get his assistance in following the coordination through the commander, then yielded success for you. So really, when the formal organization failed you, your informal organization could garner the support you needed.

BG Dunlap: I will give you an example. I won't name anyone in particular other than there was a particular effort to bring an officer, an Army Nurse, into The Surgeon General's Office in a key assignment. The chief of the ANC Branch had reviewed the records and made recommendations to me. Of course he wouldn't have wanted that because she was supposed to make recommendations to him. He wanted the recommendations to go to him, and he would say who would come in

to this assignment. I then discussed with him my recommendation regarding who should fill this position. He did not want that individual in that assignment. He had come from positions where he did not know nursing personnel. I felt as Chief of the Army Nurse Corps, I was The Surgeon General's staff officer on Army Nurse Corps functions. That was my responsibility. I was his consultant on service or personnel. The director of AMEDD PERSA did not want this individual and would not recommend this individual to The Surgeon General. What are you going to do? That individual was going to be working in AMEDD PERSA. The commander of AMEDD PERSA didn't want that person even though that was the person I felt was the best person for that job, but with him there was no way. Was The Surgeon General going to tell him he has to have that person because I wanted her? It was a person working under his command. It wouldn't be fair to the individual. If The Surgeon General backed me and we put that person in there knowing that the commander didn't want her, it wouldn't be fair to her.

So there were times when I retreated. I retreated to win because eventually we were able to get a fine person in there who did a tremendous job for us in that particular assignment.

But it is the people, the structure of Health Services Command, The Surgeon General, AMEDD PERSA. It takes the people to make it work. If you have people in it that are going to throw bottlenecks in there, it is not going to work. That is simplifying it.

RELATIONSHIP AS CHIEF WITH THE WOMEN'S ARMY CORPS

MAJ Gurney: General Dunlap, we have talked on several occasions, even during our discussions of World War II, about the relationship of the ANC and the WAC. As you were Chief of the Army Nurse Corps, we still had the Women's Army Corps. What was the relationship between the Women's Army Corps and the Army Nurse Corps?

BG Dunlap: The Chiefs or the Corps?

MAJ Gurney: All of the above.

BG Dunlap: Oh. That is my answer, all of the above. (Laughter)

I think I told you the first time I had met WACs was in New Guinea. I won't repeat all that. I also worked with them in our hospitals during the years that followed. I worked with Betty Clarke, who later became Major General Betty Clarke and Chief of the WACs, when she was the WAC staff adviser at Fourth Army headquarters. I had worked with a number of WAC staff officers in different assignments.

When I went in to be chief of the ANC Assignment Branch, the Director of the WAC—they were called Directors, not Chiefs—was Liz [Elizabeth P.] Hoisington. I met Liz Hoisington when she was Director. She retired just a month before General Hays. Her replacement was Mildred Bailey. We called her Inez.

That is why I was hesitating. She was known as Inez Bailey, not Mildred Bailey. She was promoted to be the second general as Director of the WAC, a month prior to the time I was. She is the Director then that I worked with in my tour as Chief of the Corps.

We were two entirely different people. We had two entirely different groups to serve as Chiefs. We all had a common mission. The Army was our mission. She had the big problem of a constituency of both enlisted and officers. Her problems related to recruiting, the shortages in recruiting and trying to get more women in. She was faced with the problems of trying to get women in MOS's other than clerical and hospital/medical MOS's. She had to try really hard to make careers in other fields more attractive to them. She was also dealing with a much younger group than I was because, to be an officer, candidates were at least 21 years old, and here, she had 17-, 18-, 19-year-old youngsters right out of high school.

Uniform Issues

When Army policies related to women in the Army were discussed, they pertained to all the women. If you are talking about uniforms, the two of us sat on the Uniform Board. She was thinking about what will appeal to those 18- and 19-year-olds to attract them to the Army. I was focused on a group of professional women. We had different concepts of how one should dress. We worked together many hours on the uniform. She was anxious to have a uniform that was more feminine. We agreed on that. But that is when the Jolly Green Giant uniform was developed. We had a one-piece dress and a jacket that fit over it. We also had a skirt, blouse, and jacket. The uniform replaced the green and white striped cord.

MAJ Gurney: That is the uniform we frequently called the mint green.

BG Dunlap: You may call it that. We called it the Jolly Green Giant uniform. (Laughter)

BG Dunlap: And then there was the hat. That is where we were in great disagreement. I never did approve of the beret. She wanted the beret and wore it all the time. She slept in it, I think. I preferred the visor hat. I thought it was military and certainly compatible with the visor hat the male officers were wearing. I felt that when we were in formation, or in a group—not at a meeting or something—we looked much more professional and military with a visor hat. This was a time when hairstyles were all bouffant hairstyles. Some of us never change our hairstyle, but some were wearing those teased bouffant hairstyles. They didn't fit under the visor hats. The berets were plopped on the head in any position that the individual wanted, behind their curls or bouffant or anything else. To me it was, and still is, the most unmilitary head covering that we have ever had.

We had a green raincoat, and we had the green overcoat. It was a double-breasted overcoat, very smartly tailored with a zip-out liner. They wanted to reduce the "uniform bag" issued to the enlisted personnel. So to eliminate an overcoat and a raincoat, the all-purpose coat, a London Fog raincoat, was developed. I insisted

that the green overcoat be an optional item because I wore that overcoat when I was standing in any formation or making staff visits to headquarters in cold weather, not rainy weather.

We each were concerned about uniforms, and we had differences of opinions because we were each thinking of the particular group that we had responsibility for. We eventually arrived at some decision because all women officers wear the same uniform and all women enlisted wear the same uniform.

When it came to discussing the uniform that the enlisted women wore in the hospital, we would coordinate with her, but she really left that up to us. She agreed with whatever we wanted. Sweaters were another issue. I don't want to spend hours talking about uniforms, but the enlisted women were given the fatigue jackets then. Now you call them BDUs. Then they had to have another item issued to them. It all boils down to cost again, for the costs of the issue of uniforms to the enlisted personnel had to be kept as low as they possibly could. They tried not to have many optional items so that there is more uniformity for the troops. We worked very closely on uniforms.

Role of the Woman General

The role of a woman general was still new. Liz Hoisington and Anna Mae had been general officers for one year when they retired. Well, Inez and I, then, were the first two to complete our full tour as Chief or Director as a general officer. It was still new, and we were feeling our way around. There are many formal functions in the Washington area. We were both single. What do you wear to these functions? We sometimes coordinated with each other when it came to this. We both were active in DACOWITS [Defense Advisory Committee on Women in the Services] and attended those meetings, serving in an advisory capacity to that group. We attended ceremonies together. We actually worked together beautifully. I respected her and I think she respected me and appreciated any areas where we had differences and why there were differences.

I also worked with Colonel Bettie J. Morden, who had been the deputy director of the WAC at that time. She was later called back to write the history of the WAC. I worked with her very closely. At the hospital level, our chief nurses had the enlisted personnel assigned to nursing service. They came under the troop commander, but AR 40-6 gave nursing functional control. I think that how the two groups get along depends on people. There weren't many big problems because you had enlisted women in the detachment and the chief nurse in control.

By that time we had lived through the growing pains, and I am not saying we didn't have any pains at all because we did. We supported each other, and this is true of the women in the other services, also, the Chiefs of the other services. Major General Jeannie Holm was Brigadier General Jeanne Holm at that time and Director of the WAF. I worked very closely with Jeannie because we were all pioneers in the role of a woman general officer.

I remember when Secretary of Defense Melvin Laird was getting ready to leave office. He called and asked all of us who were women generals and the first two generals to come to his office. He wanted to meet with us. We had a very nice

visit with him, and he thanked us as the pioneers and stressed the fact that we were role models. We had established the success of women generals that depended a great deal on how those in the beginning functioned and were perceived and accepted. He was very proud that this had come about during his administration.

So I worked with the Director of the WAC and served on some boards and committees with her. It was a good relationship. The WAC was discontinued as a Corps, and women are integrated into the Army now. But I think there was a good relationship then with Betty Clark and it continued under General Parks until the time when it was discontinued.

MAJ Gurney: 1976.

BG Dunlap: Yes, the year after I left

Impact of Service as Chief

MAJ Gurney: What was the impact of being Chief of the Army Nurse Corps on you as an individual?

BG Dunlap: I always tell people I was six feet tall when I went into the Army and I stuck my neck out so much I got it chopped off and I retired at five-foot-two. (Laughter)

MEETING THE EXPECTATIONS OF THE ROLE

Some of that height was lost during the four years as Chief of the Corps. The impact it had on me? When I was selected to be Chief of the Corps, naturally I was honored. I realized that there would be four years of total commitment to the Corps. I told my family, living here in San Antonio where I would be coming on staff visits to the academy or elsewhere, that during those four years they probably wouldn't see much of me. They understood because they knew me. But I felt very strongly that those four years as Chief of the Corps had to be a total commitment to the Corps. I began service in '71, and my Daddy, some of my sisters, and family all came up for the ceremonies, the "crowning" as they say, and we had a grand and glorious time. Daddy died in January of '72. I came home on emergency leave when he was sick. But truly, I did not have much time for my family, time to take leave and come home and be with my sisters or my family. When I came down to the academy, I would stay at home and they would say, we see you when you come in at night and when you leave in the morning or if you come to change uniform before you have to go out to a night affair. That is about what it amounted to. But they knew what to expect, and they were at least grateful that they saw me going and coming. That is the personal impact it has.

There were things that I did that I felt obligated to do to represent the Army Nurse Corps. I felt very strongly, as Chief of the Army Nurse Corps, that there were certain expectations of me by the AMEDD, by members of the Corps, and

certainly by DA, DoD, and the profession. That continues today in retirement. As one of the early general officers, there were certain expectations for general officers that you didn't have for a colonel. For example, the Chief of the AMSCs was a colonel, still is. There were meetings within The Surgeon General's Office, conferences for general officers. Everybody would be there but the Chief of the AMSCs because she was not a general. I would stop by her office and say, "what do you want me to present for the AMSC at this meeting?" But I made this known to The Surgeon General because I felt that she should be included. It was just like when The Surgeon General had conferences and he would have his general officer commanders of the medical centers there. At that time the CONARC Surgeon was a colonel and he wasn't included, although he was the CONARC Surgeon. I can remember that at one meeting I said something to The Surgeon General about it. After all, he is CONARC Surgeon and even though it wasn't a general slot, he should be there.

So there were expectations. There were meetings, conferences, just for general officers, and I certainly went to every one of them that I possibly could. I knew that there were only two of us women generals in the Army. We both wanted to represent the women in the Army well by attending and participating in these conferences. This is true in civilian life. Women are moving into executive positions. You have heard it said over and over again how women have to work twice as hard to get recognized in a position. I am not saying I worked twice as hard as anyone else, but I was very much aware that I had goals to fulfill and expectations of the different groups.

As an individual, I would not have attended many of the social functions that I attended because I am not a person who likes to go to cocktail parties and receptions. I would rather go fishing or play golf or go traveling or something like that. But I felt that I represented the Army Nurse Corps and they should have representation at these functions. So that was one way that being Chief impacted on me.

There were many positive things that happened to me as a result of being Chief of the Corps. I met so many wonderful, interesting people, as I had an opportunity to visit all of our stations. I met the post commanders. You know the routine, the entrance interview with the post commander, the hospital commander, the chief nurse. Then you make your visit and you have exit interviews. I met some tremendous people. I also met them in the civilian community as I went into the community. There were social functions or conferences in places around the world. When I visited Europe, I would always speak at the med-surg conference and then tour our stations. I got to know the Chief of Queen Alexander's Royal Army Nursing Service, or the Chief Nurse of the British Army Nursing Service. I knew two of them. I also got to go to Ethiopia because we still had our station in Asmara. I got to go to Tehran because we still had a hospital there, and I met some people in those countries. One of my biggest regrets was that I did not get to every Army hospital in CONUS. I made them all overseas, but I did not get to every one in CONUS. The reason I did not was that for about a half a year in there, following surgery, my traveling activities were restricted a little bit to the

Washington area. Then budget limitations came about that period of time. I would like to have been able to get to every one of the stations. I got to many, many of them, certainly all the medical centers and many of the smaller stations.

Being the Chief of the Corps made me more aware of the historical significance of the past and what had happened in the Corps. I realized the importance of trying to preserve this history and make it known. That is one reason I initiated some of the things that happened when I was Chief. It also drives some of those activities I continue in retirement. We are working to capture some of this history and collect any artifacts and memorabilia so that it can go into our new museum and be available to the public. That's why I feel it's important to participate in ANC History Day because so much of it is lost. That is the business you are in. But so much of it is lost and it won't be found if we don't do something about it, because the people who made it are going to be gone.

I think this is one thing that [Major] General Spurgeon Neel and I have talked about related to our museum. We feel an obligation to try to get that history, that we were part of making, recorded and available to the museum for those who follow us. That is why we work so hard on the museum. We certainly become much more aware of that as people ask the Chief questions, sometimes weekly, about somebody or some incident. We contact the nurse out at the Historical Unit. That is what I would do. I'd be looking for a record of something or if the Army Nurse Corps historian knew anything about the situation or the issue. We have talked about lessons learned. We learn from our history, and we have to have it available to us.

THE IMPACT ON HEALTH

MAJ Gurney: Do you feel that your period as Chief had an effect on your health?

BG Dunlap: I went into the role in September of '71 in good health. In '72 I had to have surgery for endometrial cancer. I had to have the radium implant prior to that time and then the surgery the day before Thanksgiving of '72. That did take a little steam out of me. I was back on duty in six weeks. But once I got my strength back from that it certainly had no adverse effect on my functioning. I experienced a little neurological complication at the time of surgery.

MAJ Gurney: So you were on medication for a while after that surgery?

BG Dunlap: I was on Dilantin for a period of time and followed very closely for the neurological problem. I also had the post-op follow-up for cancer to be sure that there was no metastases or anything like that. Everything cleared up, worked out beautifully, no problem.

As far as the rest of my tour as Chief, I guess the main thing was eating at all the banquets. My diet perhaps was not the most nutritious food, and I couldn't take time to eat as I should eat. I took my lunch to the office and I might sit there and conduct a staff meeting with the assistant chief of the Corps while we had

lunch. That wasn't healthy. But it happens in The Surgeon General's Office. You don't have to be Chief for that. It happens in Washington, and I know that. But when I retired, other than having put on some weight, I've been fine. Over the years I had put on about 15 pounds from the time I was sworn in until I retired. I was not aware of any physical problems.

Certainly during that time there would be periods when I was physically exhausted. I would be out on these trips and going constantly. I'd get back in on Saturday, get my clothes laundered so I could go to work Monday. You've experienced the same thing. But that happens with everybody in an assignment in the Washington area. I considered myself to be in good health when I retired.

MANAGING THE STRESS

MAJ Gurney: What does someone do in that kind of position, as stressful and demanding on the individual as it is? What did you do to survive it?

BG Dunlap: It depends on the individual, the outlets that individual possessed. When I was in the position, there were three of us Army Nurses who lived together in a beautiful home out near Annandale. It had a great big yard. For me, there is nothing more relaxing than to get out and work in the yard. Even if a person uses a riding lawn mower, it can be therapeutic. They wouldn't let me use it. I would have to use the little one and do the trimming.

Leaving the office and getting involved in some physical activity like that was my release. It always has been. When I was assigned to the Medical Field Service School teaching, I would come home from work distressed that the students hadn't passed exams or I was faced with some situation at work. I would go out in the yard and start digging in it and planting something. When I bought this duplex it was new, and there was nothing in the yard. When I left here five years later, it was almost like a jungle I had dug so many holes and planted so much to relieve the frustration like that.

I am a person who likes physical activity to relieve the stressful situations. With three of us living together it was an active house. One of the individuals had a sister, and her family was just a couple of miles from us. I was able to go over there and I became "Aunt Lil" to the children. I could be involved in things like that. I also attended the Annandale Methodist Church and was involved in that. That is the way my stresses were relieved.

As Chief, you need to talk with someone sometimes. It is very difficult to hold everything within you. You have to find someone who is not in that situation. I found that person and I was able to do it.

I had done this even in my first chief nurse assignment. I was chief nurse at Camp Chaffee, and the chief dietician was Mary Lipscomb. She later became Chief of the AMSCs. We were both captains, and we would go play golf or we would go fishing or picnicking or do something together. We went up into the Ozarks and drove through the Ozarks, or something like that. We helped each other relieve some of the pressures by being able to speak out, as we would say. "Go

ahead and speak it out, get it off your mind." We would, and it would stop right there.

MOST SIGNIFICANT CONTRIBUTION TO THE CORPS

MAJ Gurney: If you were to take a look back at that four years, or really let's look at 33 years, what would you say was your most significant contribution to the Army Nurse Corps?

BG Dunlap: I survived! (Laughter) That is the \$64 question, in the 33 years, I survived.

I don't think you can pinpoint one thing because during the whole 33 years, I was involved in all the different aspects of the Corps, clinical in the hospital, certainly in teaching, and research with the Research Unit. I was in combat. I was in administration.

Firsts

I would hope that I made some contribution in each of those areas where I was assigned. I had a number of firsts, being the first Army Nurse to do this or that. Like when I was at the academy, I was the first Army Nurse to be appointed an assistant professor at the graduate school in Baylor because I taught in the hospital administration course. I was the first Army Nurse to be a nominee for the College of Hospital Administrators. Later, I was the first woman general to serve as president of a DA promotion board. There were a number of things like that. But being the first isn't necessarily the greatest accomplishment.

MAJ Gurney: What if you were to trim that question down to just looking at your four years as Chief? What do you think was the biggest contribution or the biggest achievement of those four years, the most important?

GEN Dunlap: I would say two. The Army Nurse Clinician Program, the design and implementation of the Army Nurse Clinician Program. Secondly, I raised the educational level of the Army Nurse Corps. The Army Nurse Clinician Program impacted on the clinical aspects of patient care. Raising the educational level of our Corps certainly impacted on our role not only as professional nurses but also as professional military.

Those are possibly the two most significant contributions.

Unfinished Business

MAJ Gurney: Were there any things that you really wanted to achieve or to accomplish that you just weren't able to? Perhaps your time just ran out, and it was something you couldn't get within your watch, as they say?

BG Dunlap: You sound like the Navy. Of course, you never finish your job. You never get everything done that you want to do. The history was one of them, get-

ting the history of the Army Nurse Corps written. And, my goodness, I worked hard at that. [Lieutenant Colonel] Polly Maxwell worked so hard at that and she had done so much. She retired and was working on it in an unpaid status. She volunteered her time working on it. I was able to get her appointed as a consultant so that she could at least get travel, but it was a limitation because of her retirement status. But I really wanted to get a published history of the Army Nurse Corps. I was very frustrated that I could not make any more progress than was made at that time. I am not the only person who was frustrated about that, but I really wanted to get that accomplished.

When I left we still had the WRAIN program. We had been able to battle to save it up to that point, but the handwriting was on the wall. I was not successful in defending that so we ultimately lost our WRAIN program. I still feel that we should have the WRAIN program or some program similar to it. It had so many advantages for graduates. I hope someone is doing a follow-up on our WRAIN graduates. That was one question we always had trouble answering when we were trying to justify anything. What percentage of the WRAIN graduates remained on duty one year beyond their commitment, two years, three years, and so forth? I hope that type of thing can be documented someplace because that was the second time the Army had established an Army School of Nursing. If the time ever comes again that they want to consider doing it because of the need for large numbers of nurses, usually a wartime situation and particularly with the projected shortage of nurses in our country, I hope that we have the statistics to guide us in the establishment of a new program.

I was not satisfied with our uniform situation or the housing situation for our nurses. Those are things we worked on continually. Promotions were an area that I was not satisfied with. We had made progress, but not as much as I felt that we needed to make. They had been talking DOPMA [Defense Officer Personnel Management Act] for years and it still had not been passed. So I didn't function under DOPMA, but as it was presented in briefings, we were led to believe that DOPMA was the savior coming. It was going to cure all of our ills. But some of us anticipated some problems for the Army Nurse Corps promotion-wise. Thank goodness, I wasn't there.

We had tremendously large numbers of officers who came into the zone of consideration for promotion, and we could select so few out of that zone. It was disheartening to see good people not selected because of the limitations. Then we were faced with the conflict, are you going to select from the secondary zone? I know there were some times when no one was selected from the secondary zone. Then you have to think about your young officers, the truly outstanding young officers. They need a career incentive; maybe we could select one, two, or three from the secondary zone out of such large zones of consideration.

We saw improvements, yes, but not as many as I would like to have seen.

The position of the Chief of the Army Nurse Corps, in my opinion, should be an Assistant Surgeon General position. That is what exists for the Chiefs of the Dental Corps and the Veterinary Corps, particularly the Dental Corps. You have an Assistant Surgeon General who is the Chief of the Dental Corps. He is a major

general. I think the Chief of the Army Nurse Corps should be an Assistant Surgeon General. I do. But the time, situation, and the limitations were not right for that. It didn't happen during my administration, but I was proud that the seeds were planted during my administration.

We had the hospital at Fort Campbell named for a Chief of the Army Nurse Corps, the Florence Blanchfield Hospital. That had been promised during my administration, and General Parks was able to follow through on that during her administration to see that it happened.

Unfinished business—if I ever get into those papers out there, I may find some of those things that were unfinished.

The reserves, we made great strides in the reserves to meet the quota that had been established. But every time we almost got there, then they would give us more spaces to fill. I was not able to get the educational level of the reserves to parallel that of the active duty nurses. Strides were made in that, but not completely accomplished.

That is all I can think of right off the bat.

THE RETIREMENT ROLE

MAJ Gurney: As a retired Chief of the Army Nurse Corps, you have been very, very active in just a phenomenal number of activities, including the board of directors of several different institutions, banking institutions, life insurance. You have been involved in civic organizations and state organizations. You have been involved in the Retired Army Nurse Corps Association and in the Army Medical Department Museum Foundation. Your activities have been just phenomenal.

This obviously illustrates a little bit of your idea of the role of a retired Chief of the Army Nurse Corps. What do you feel that role is for that individual once they have retired? Does the "former chief" continue to play a role in the Army Nurse Corps?

BG Dunlap: It is based on the individual's desires and what they plan in retirement. It doesn't have to be the Chief of the Army Nurse Corps. Look at The Surgeons General and anyone else who has been in a leadership position. It doesn't have to be just a leadership position. It applies to anybody coming up for retirement. But it is probably more noticeable in those who have been in leadership positions. Do they stack arms? That is the term that is used sometimes. Do they put their military career behind them and do things in retirement not associated with the military? That was not my style. I did not want a job. I had been offered a number of jobs in the health care field, and I said, no, I did not want to work full time. I don't want to have to punch a clock. My whole adult life I have worked because I went from nurse's training into the Army Nurse Corps nine days after I graduated. So my whole adult life I had worked, and I did not want to work. I am not a rich lady and I wasn't rich then, but I knew that I could live on my retirement pay.

There were things that I felt I had not been able to do during my active duty career that I would like to get involved in. One of them was "Meals on Wheels,"

but I still haven't gotten involved in it. Our church in Annandale was quite active in it. I couldn't because I was out making staff visits or doing this or that and I couldn't be depended on to be available at a certain time to do that type of thing.

My decision was to return to San Antonio. I have sisters living here. This is my home. I grew up here. Of course it is my second home as far as military is concerned because this is the home of the Army Medical Department. But I decided I wanted to return to San Antonio. About six months after I retired I came on back to San Antonio. I had been approached by the chairman of the board of the National Bank of Fort Sam Houston and asked if I would consider serving on the board of directors. I had had my account at that bank since my first paycheck—well, we didn't get paid in checks at that time. We got paid in cash when I got my first pay as a second lieutenant. I knew nothing about banking, but I indicated to him since I would be the first woman to serve on the board that if I was their token female, they could forget it. He assured me that members of the board who knew me, like [Major] General Kenneth Orr and some of the others I had served with, insisted that I would not assume a token role on any board I served on. So they took their chances, and I have served on that board since 1976.

I was approached by the president of Incarnate Word College to see if I would be interested in serving on their board. I had graduated from Incarnate Word. I was honored, and I accepted and served for 10 years on their board of trustees.

Many different groups and individuals approached me because I was in my hometown. I am proud of my career, but people who knew my family and know me are proud of my career, too. At that time I was the only woman general in San Antonio, and every place I went I was "the General" in San Antonio. There are how many hundred men generals around here? When I realized this, I guess I still felt I needed to fulfill my obligation to this role because there are so few women generals. Now, in San Antonio we have three Air Force women generals retired here and General Parks and I are here. So five women generals retired in San Antonio is a large, large number.

Since I am the hometown girl, I am included in many of the activities around here, and I do participate in many things, but I get so much out of it. I belong to the American Association of University Women and have served on its board every year but two since I retired.

As far as the American Nurses' Association, I am a member and I support them, but I am not active in it. There were a number of hospital or nursing areas that I was asked to serve on, and I declined. I said all of my life has been in that area. I have fought those battles, and I do not want to continue to do that in my retirement. I want to feel that I am learning something and doing something different. That doesn't mean that I am not available for consultation, but I don't want to tie myself down in just that area and just continue in that area.

I am also on the Government Personnel Mutual Life Insurance board, one of two women on that board. Our mayor started Target '90 Goals for San Antonio, and he asked if I would serve on the Target '90 Task Force on Biosciences. I served on that, and that then led into the Target '90 Goals for San Antonio. I have been serving on the board of directors for that.

The governor appointed a Governor's Commission for Women and asked if I would serve on that. So I served on the Governor's Commission for Women for two years. We have a Mayor's Commission on the Status of Women. As a member of the Governor's Commission, I was asked to be an ex officio member of the Mayor's Commission on the Status of Women. One thing just leads into another. We have a Fiesta of San Antonio Association that coordinates the Big Fiesta activity in San Antonio each year. I had first participated in that at age 6, when I was in the first grade. Our school had a float and they wanted a representative from each grade. The votes were a penny a vote. My friends must have robbed their penny banks because I won for the first grade and rode the float as the first grade representative. When I was asked then if I would serve as a commissioner on the Fiesta Commission, I accepted it and became involved in that. On that commission you serve a three-year term. Then you have to stay off a year and can be reelected. I am in the last year of my third three-year term on the Fiesta Commission. You can become really involved in the community as such. This past year I was asked to serve on an allocation panel of the United Way here in San Antonio. I did this, and by doing this I was able to visit with the panel in four of our community service centers for briefings to evaluate their request for funding and to make recommendations. One of the areas of concern of the Governor's Commission for Women was child care. So I represented the Commission on the United Way of Texas Child Care Working Group up in Austin.

This goes on and on, but I think you can see the diversity of areas in which I am involved in the civilian community. I am still involved in the military community because being here at Fort Sam Houston, near the academy and HSC, there are many promotions and retirements and all kinds of functions and conferences. In 1976 General Parks, as Chief of the Army Nurse Corps, visited San Antonio. Those of us retirees living here, 38 of us, got together on November the 2nd, 1976, to discuss what we could do to support General Parks in collecting and preserving the memorabilia of the Army Nurse Corps. Her concern was that the portraits of the Chiefs of the Corps and all of the other artifacts from Delano Hall at Walter Reed had to be sent for storage since the building was being converted for other uses. As a result of that meeting, the Retired Army Nurse Corps Association was organized. We recognized we wanted to support the Chief of the Army Nurse Corps. We wanted to support these efforts, but we did not want to take on the responsibility of collecting and raising funds to build a museum or some place where these things could be stored.

As a result we organized the Army Nurse Corps Foundation. Both of these organizations were incorporated as tax-exempt organizations in the State of Texas. The Army Nurse Corps Foundation then had as its responsibility to collect memorabilia, artifacts, and raise funds to find a place to store these and exhibit them. It became evident that instead of just an Army Nurse Corps Museum, we should attempt to have a total AMEDD Museum.

General Neel was commander of HSC. We discussed this with him. As a result of our discussions with him and later with General Pixley, who was commandant of the Academy of Health Sciences at the time, we incorporated the

Army Medical Department Museum Foundation for the purpose of raising money to build the museum. Once built, we would turn it over to the Army to become a part of the Army Museum System. In each of these organizations I was involved in either the bylaws or the charters or, like the ANC Foundation, I served as the executive vice president of that. For the AMEDD Museum Foundation I was chairman of the Incorporation Committee, which included the bylaws. I learned about how you incorporate an organization in the State of Texas and made many trips to Austin to do it. I have served as vice president and now president of the foundation to raise funds.

One thing just leads to another. One thing I have had difficulty doing is saying no. I know that I overextend myself in doing these things, but I get a great deal out of it, and I hope I am able to give something. I think this is something that is important. As an Army officer and as an Army Nurse Corps officer, there are certain skills and abilities that we acquire during this type of career that we may not be aware of. It relates to organization and how to do things. When you return to the civilian community you are in great demand, whether as a nonpaid volunteer or on boards. We don't realize that, and you don't just have to be Chief of the Army Nurse Corps to get that recognition. I think all of our Army personnel learn to accept responsibilities, and I feel very strongly about this. We were given a job to do far and above what we may have done in the past, but we didn't question whether we could do it or not. We did it.

The first chief nurse job I was put in, I had never been a chief nurse before. I didn't say, "Oh, I don't think I can do that, no, no, no." It was a challenge. I did it. You develop a "can do" philosophy when you are in the military because in each assignment that you are sent to, I would hope that you encounter something new. You learn and progress in your career. As a result then, you develop this philosophy. So when you then retire and you are asked to serve on committees and do things, you know how to take hold and organize and do it. That is one of the big benefits of a military career that you can't put on a recruiting poster. Just like the many friends that you make around the world.

It is hard to represent that on a recruiting poster when you are talking to a youngster. You see that right here in San Antonio. With such a large retired community, we are truly an Army family, an AMEDD family here. We support each other in retirement just as we did when we were on active duty.

MAJ Gurney: Is there a role for the retired Chief in relation to the active ANC?

BG Dunlap: Well, again this depends on individuals.

MAJ Gurney: Do you see the retired ANC Chief possibly being a role model for young ANC officers who may encounter the Chief in whatever situation or activity they may find? Do you think that person can be a role model?

BG Dunlap: Yes. You have had the top position in the Army Nurse Corps. Certainly the Chief of the Army Nurse Corps does not equate with the President

of the United States, but in theory he holds the top position in our country and you know how we all look to past presidents with respect, in awe sometimes. We have expectations of them in retirement as we do our former presidents.

This is true of Surgeons General and of Chiefs of the Army Nurse Corps. By being here in San Antonio, I meet so many of our young Army Nurse Corps officers. They are all real excited to meet the Chief of the Corps, just like you and I were the first time we met the Chief of the Corps. We never thought we would meet the Chief of the Corps. Then, to be able to talk to the Chief of the Corps and realize she is human just like everybody else is both reassuring and exciting.

So, yes, I feel that the Corps has expectations. The active duty officers certainly have expectations of their former Chiefs. As far as the current Chief of the Army Nurse Corps, it is important to have a relationship with the retired Chiefs. I speak for myself. When I was Chief, I knew all of the former Chiefs well and felt that I could call on any one of them if I wanted to consult with them about anything that came up during their period as Chief that I might be facing and need some background about. In my retirement I have told each of the succeeding Chiefs that I would certainly be available to support her in any way I could. I have been privileged to be able to provide some support if it is no more than just being able to talk with them. They can call me, and we can talk.

Here is a good example of that. This isn't any secret. I think it is known throughout the Corps. General Parks got in touch with me when the Blanchfield Hospital was to be named. The system at that time was that after The Surgeon General held the Memorialization Board, he would send out to the post commander three names that he recommended for naming that hospital in order of priority. Colonel Florence A. Blanchfield was number one on the list to go to Campbell. General Parks let me know that the nomination was leaving The Surgeon General's Office to go to the post commander. So immediately I got in touch with our RANCA members, Retired Army Nurse Corps Association members. We encouraged our retired Army Nurses and particularly our retired Chiefs to write to the post commander at Campbell to name that hospital for Colonel Blanchfield. You may call that lobbying. I don't know what it is. General Parks didn't lobby. She just told me that the nomination had gone down. She didn't ask me to write any letters or do anything like that. She just let me know. It was said, although I didn't hear it from the post commander directly, that the post commander told the hospital commander that he had received so many letters from Army Nurses and retired Army Nurses he would be afraid not to name that hospital the Blanchfield Hospital. That may be exaggerating it a little bit, but it illustrates how the former Chiefs and retired Army Nurses can support the present Chief. I think we have that role because the Chief can only do certain things legally. I am not saying we can do it illegally, but restrictions on doing things are not as severe as when you are on active duty. We have been able to support our Chief that way.

MAJ Gurney: Well, I think we are coming close to an ending here. Looking at my meager list of what to cover in this interview, I think I've included it all. Is

there anything else that we may have forgotten, may not have asked or covered, that you would like to include?

BG Dunlap: If that is meager, I would hate for you to make a complete list. That's my only comment.

MAJ Gurney: Are there other things? This is an opportunity for you to add anything you may not have had a chance to talk about.

BG Dunlap: In my retirement I have been able to watch cable TV and see the proceedings of our Congress. So, Madam Chairman, I would like to reserve the right to submit additional information for the record within a period of so long.

MAJ Gurney: Fantastic.

BG Dunlap: Really I can't think of anything. You have certainly gone throughout my career and we have had, I don't know how many hours together now, 18 tapes, is it all together?

MAJ Gurney: Nineteen, now, dear.

BG Dunlap: Nineteen tapes and many hours together. If I had been doing this with a psychiatrist, it would have been considered therapy, I think. I don't consider it therapy. I have enjoyed doing it. I just hope that, as I have recalled and related these experiences, that I have been able to recall them as accurately as possible and that whatever use is made of this in the future would be considered just that, a recollection of my experiences after 33 years. It was as I saw the situations I was in at the time. During my 33-year career with the Army Nurse Corps, I was blessed, blessed by the opportunities afforded me and certainly by the many people that I met. That continues as a retired Army Nurse Corps officer. This blessing continues because I continue to associate with the Army Nurse Corps and members of the Army Medical Department. It is an experience that many of my counterparts in civilian life never have. They marvel and are envious of what I have been able to do, where I have been able to go, and particularly of the professional and personal friendships that I enjoy as a result of a career in the Army Nurse Corps. That is one of the fringe benefits. Amen.

MAJ Gurney: I want to thank you so much for the opportunity this has given me. I think in 15 years or so, when I am ready to retire, I will probably look back on this as a highlight of my career because of the many hours that we have spent together, the generosity that you have shown in sharing all of these events and feelings with me. You've given us the opportunity to really document it for the Army Nurse Corps because I think it is going to be an excellent chronicle of 33 years of Army Nurse Corps history. I am singularly honored and I appreciate that.

BG Dunlap: Well, I thank you for being so patient with me and tolerating the little inconveniences like the phone ringing and the room air conditioner.

MAJ Gurney: No, it has been wonderful.

BG Dunlap: Now if we sound like we are getting a little sentimental here at the end, I think this is true feelings. I am so proud of what you have done and so grateful for what you are doing as far as your assignment in the history of the Army Nurse Corps. As I indicated to you I was frustrated that we could not accomplish during my time what you have been able to accomplish during your time there with the unit. I hope that your successor is able to build on what you have done just as I have been able to build on the work of others during my career.

MAJ Gurney: Well, thank you very much, dear. I hope so too.

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